OU/L

HOUSE OF LORDS

SESSION 1994-95

SELECT COMMITTEE ON SCIENCE AND TECHNOLOGY

MEDICAL RESEARCH AND THE NHS REFORMS

EVIDENCE RECEIVED UP TO DECEMBER 1994

Printed pursuant to the Order of the House of Lords of 22nd November 1994

LONDON: HMSO
£16.60 net

HL Paper 12-I

PQ

22501851662

SELECT COMMITTEE ON SCIENCE AND TECHNOLOGY

MEDICAL RESEARCH AND THE NHS REFORMS

EVIDENCE RECEIVED UP TO DECEMBER 1994

INFORMATION SERVICE
7903 28 FEB 1995 XPS/1
HOW/4
Wellcome Centre for Medical Science

Printed pursuant to the Order of the House of Lords of 22nd November 1994

LONDON: HMSO
£16.60 net

HL Paper 12-I

CONTENTS

Page

CALL FOR EVIDENCE v

ORAL EVIDENCE

Department of Health
Written evidence 1
Oral evidence, 1 November 1994 31

Medical Research Council
Written evidence 44
Oral evidence, 22 November 1994 52
Supplementary evidence 64

Council of Deans of Medical Schools
Written evidence 72
Oral evidence, 29 November 1994 80

Committee of Vice-Chancellors and Principals
Written evidence 86
Oral evidence, 29 November 1994 88

Association of Medical Research Charities
Oral evidence, 6 December 1994 95

WRITTEN EVIDENCE

Professor R A C Hughes, Department of Neurology, Guy's and St Thomas' United Medical and Dental School 106

CALL FOR EVIDENCE

Sub-Committee I have begun an enquiry into medical research and the NHS reforms. We will receive evidence in writing and in person, with a view to making a report to the House of Lords by July 1995. We invite you to submit written evidence on the following questions:

1. **What is your assessment of the NHS R&D Strategy? You may wish to comment on the centrally-commissioned programme, the role of the Regional Research Committees and Regional Directors of R&D, health technology assessment, the Cochrane and York Centres, the Research Liaison Committees or any other aspect of the Strategy. Do you have advice for the NHS Director of R&D as he takes the Strategy forward?**

2. **What is your response to the Culyer report on "Supporting Research and Development in the NHS" (HMSO, September 1994)? Do you have suggestions, or concerns, as to how it might be implemented? You may wish to comment on service support for curiosity-driven research in NHS hospitals; tertiary referrals in the internal market; the consequences for clinical trials; or any other issues raised by the report.**

3. **Do you identify additional challenges or opportunities for UK medical research which neither the NHS Strategy nor the Culyer report addresses?**

Members of Sub-Committee I are:

L. Butterfield
L. Flowers
B. Jay of Paddington (stood down)
B. McFarlane of Llandaff
L. Gregson
L. Nathan
L. Nelson of Stafford (stood down)
B. Perry of Southwark
L. Perry of Walton
E. Selborne
L. Walton of Detchant (Chairman)

INSTRUCTIONS TO WITNESSES

Evidence should be submitted to the Clerk of Sub-Committee I (Medical Research and the NHS Reforms), Select Committee on Science and Technology, House of Lords, LONDON, SW1A 0PW.

Evidence must be clearly typed or printed on one side of A4 paper and take the form of an original copy. Long submissions should include a summary. Evidence becomes the property of the Committee, and may be printed. You may publicise your evidence between submission and publication, but in doing so you must indicate that it was prepared for the Committee.

Persons who submit written evidence may be invited to give oral evidence. Oral evidence is usually given in public at Westminster, and transcripts are published.

You may follow the progress of the enquiry from the Weekly Agenda of House of Lords Select Committees. This is free, and may be ordered from Miss Sue Hunt, Committee Office, House of Lords, LONDON, SW1A 0PW (071-219 5791).

Further information from the Clerk, Andrew Makower, House of Lords, LONDON, SW1A 0PW. Tel: 071-219 6798, Fax: 071-219 6715.

MINUTES OF EVIDENCE

TAKEN BEFORE THE SCIENCE AND TECHNOLOGY COMMITTEE (SUB-COMMITTEE I)

TUESDAY 1 NOVEMBER 1994

Present:

Jay of Paddington, B.	Selborne, E.
Nathan, L.	Walton of Detchant, L. (Chairman)

Answers to written questions by the Department of Health

QUESTION 1.

What has been the progress of the CRDC Advisory Groups since "Research for Health" (1993)?

1. The following table summarises the progress of CRDC Advisory Groups since the formation of the CRDC.

Perspective	*Areas for review*	*Progress*
Disease related	Mental health and learning disabilities	Advisory Group reported on R&D priorities to CRDC in April 1992. Commissioned programme of centrally funded NHS R&D now managed by Northern and Yorkshire RHA. The first projects have now been completed. Other priorities taken forward by MRC and RHAs.
	Cardiovascular disease and stroke	Advisory Group reported on R&D priorities to CRDC in April 1993. Commissioned programme of centrally funded NHS R&D now managed by Northern and Yorkshire RHA, and the first projects are expected to be completed in summer 1995. Other priorities taken forward by MRC and RHAs.
	Cancer	Advisory Group reported on R&D priorities to CRDC in July 1994. Programme of centrally funded NHS R&D now being commissioned by South and West RHA. Other priorities being taken forward by MRC and other member bodies of the UKCCCR.
	Diabetes	Report on R&D priorities to be considered by CRDC in October 1994.
	Dentistry	Report on R&D priorities to be considered by CRDC in October 1994.
	Asthma management	Advisory Group being convened, to report to CRDC early 1995.
	Nutrition	Report on R&D priorities to be considered by CRDC early 1995.
Management and organisation	Interface between primary and secondary care	Advisory Group reported on R&D priorities to CRDC in October 1993. Programme of centrally funded NHS R&D now being commissioned by North Thames RHA. Other priorities being taken forward by MRC.
	Implementation of research findings in the NHS	Advisory Group to report on R&D priorities to CRDC early 1995.

Perspective	*Areas for review*	*Progress*
Client groups	Physical and complex disabilities	Advisory Group reported on R&D priorities to CRDC in July 1993. Programme of centrally funded NHS R&D now being commissioned by South and West RHA. Other priorities being taken forward by MRC.
	Mother and child health	Advisory Group to report on R&D priorities to CRDC in December 1994.
Consumers	Involvement of patients and public in decisions about health care and health service provision	Research agenda explored through commissioned paper and workshop. Consumer perspective integrated within the work of all Advisory Groups.
Health technology	New and existing health care interventions	The Standing Group on Health Technologies (SGHT) with six advisory panels, convened in 1993. First annual report on priorities for technology assessment to CRDC in December 1993. Programme of centrally funded NHS HTA now being commissioned by NHS Executive. Other priorities being taken forward by MRC. The Group's remit also involves assembling an inventory of health practice methods and identifying new and emerging technologies. The Standing Group provides a mechanism for ensuring that the NHS is aware of technological advances. In rapid growth areas of science and technology, the Standing Group is advised by specially convened groups. A report on the implications of advances in genetics for the NHS will be published shortly. A review of the implications of advances in biomaterials and implants is in hand.
Research methods	Identification and development of methods to tackle the full range of R&D of interest to NHS.	SGHT methodology panel has identified initial priorities. Work is being commissioned.

2. With the exception of the Standing Group on Health Technology, Advisory Groups are time-limited and disbanded after reporting to CRDC.

3. As explained in "Research for Health" (1993), Advisory Groups are multi-disciplinary, bringing together medical and non-medical scientists, NHS clinicians and managers, and consumers. All groups consult widely. The commissioning of centrally funded NHS R&D addressing the priorities identified in each area is overseen by Programme Directors, advised by expert commissioning groups.

QUESTION 2.

What is the current membership of the Central Research and Development Committee (CRDC)?

4. The Central Research and Development Committee (CRDC) and the expert advisory groups convened under its auspices provide advice on the development of the strategic framework of the NHS R&D strategy. The current membership of the CRDC is shown below:

Professor Michael Peckham (Chairman), Director of Research and Development, Department of Health.

Professor Ross Anderson, Professor of Public Health, St. George's Hospital Medical School.

Professor Martin Bobrow, Professor of Paediatric Research, United Medical and Dental Schools of Guy's and St Thomas' Hospitals.

Mr John Brassington, Regional Director of Finance, Trent Regional Health Authority (RHA).

Professor Alasdair Breckenridge, Professor of Clinical Pharmacology, University of Liverpool, and Regional Director of Research and Development (RDRD), North West RHA.

Professor Anthony Culyer, Deputy Vice Chancellor and Professor of Economics, University of York.

Professor Sir Colin Dollery, Dean, Royal Postgraduate Medical School, Hammersmith Hospital, and Pro Vice Chancellor for Medicine, University of London.

Professor Liam Donaldson, Regional General Manager/RDRD and Director of Public Health, Northern and Yorkshire RHA.

Professor David Goldberg, Professor of Psychiatry, Institute of Psychiatry, University of London.

Dr Marion Hall, Consultant in Obstetrics and Gynaecology, Aberdeen Maternity Hospital.

Mr Terry Hunt, National Director, NHS Supplies Authority.

Baroness Margaret Jay, Member, Kensington, Chelsea and Westminster Health Authority.

Professor Kay-Tee Khaw, Professor of Clinical Gerontology, University of Cambridge.

Mr Alasdair Liddell, Director of Planning and Performance Management, NHS Executive (formerly Regional General Manager, East Anglian RHA).

Professor Karen Luker, Professor of Community Nursing, University of Liverpool.

Professor Lindsay McLellan, Professor of Rehabilitation, University of Southampton.

Professor Alexander McNeish, Professor of Paediatrics and Child Health, University of Birmingham, and RDRD, West Midlands RHA.

Professor John Newsom-Davis, Professor of Clinical Neurology, University of Oxford.

Sir Dai Rees, Secretary and Chief Executive, Medical Research Council.

Professor Crispian Scully, Dean and Director of Studies, Eastman Dental Institute for Oral and Dental Health Care Sciences.

Ms Barbara Stocking, Regional General Manager/RDRD, Anglia and Oxford RHA.

Professor Nigel Stott, Professor of General Practice, University of Wales College of Medicine.

Professor John Swales, Professor of Medicine, University of Leicester.

Professor Nick Wald, Professor of Environmental and Preventive Medicine, St Bartholomew's Medical College.

Professor Peter Wells, Chief Physicist and Honorary Professor in Clinical Radiology, Bristol General Hospital.

Observers

Mr Strachan Heppell, Deputy Secretary, Health and Social Services Group, Department of Health.

Dr Jeremy Metters, Deputy Chief Medical Officer, Department of Health.

Mrs Yvonne Moores, Chief Nursing Officer, Department of Health.

QUESTION 3.

What Research Liaison Committees are now in being, and what have they achieved?

5. Research Liaison Committees (RLCs) were established to promote better understanding of the strategies and priorities of research funders. In particular, their purpose has been to identify gaps in the overall coverage of research, to be aware of potentially unproductive duplication and to examine the advantages of complementary strategies and opportunities for collaboration on specific projects.

6. Three RLCs have been convened to bring together public and private research funding bodies in the following areas:

> The Cardiovascular and Stroke RLC was constituted in July 1991 and its members include the MRC, British Heart Foundation, Wellcome Trust, Stroke Association as well as the Department of Health (DH) and Scottish Office Home and Health Department (SOHHD).
>
> The Respiratory RLC, formed in March 1992, has among its members the DH, SOHHD, the British Lung Foundation, MRC, National Asthma Campaign, the Health and Safety Executive, Wellcome Trust, British Thoracic Society, Cystic Fibrosis Trust and Association of British Pharmaceutical Industries.
>
> A Biomedical Technologies RLC was also established in 1992 and its membership included the DH, SOHHD, DTI, MRC, the former Science and Engineering Research Council, the Economic and Social Research Council, Association of British Healthcare Industries, and the Association of Medical Research Charities.

7. The Cardiovascular and Stroke RLC meets between once and twice a year and provides an opportunity to consider current research activities from a wider perspective. Membership is at a senior level. The committee was initially chaired by Sir Raymond Hoffenburg, former President of Wolfson College, until he was succeeded by Professor Desmond Julian, former Medical Director at the British Heart Foundation. The Department of Health provides the secretariat for the committee.

8. The Respiratory RLC has met on five occasions since its establishment. The next meeting is on 7 October. It has agreed to identify research gaps where trials may be needed, and it has also created a database of respiratory research funded by member organisations. The chairman is Dr Donald Lane, a nominee of the National Asthma Campaign. The MRC provides the secretariat for the committee.

9. The Biomedical Technology RLC met twice in 1992. It was responsible for identifying technology transfer as a suitable subject for a study. It was agreed by the RLC that it was not considered the most appropriate vehicle to develop this work which was eventually commissioned through the Centre for Exploitation of Science and Technology (CEST). CEST is due to publish its findings on technology transfer in November. The RLC also identified the need to explore and optimise relationships between the NHS and industry, and an NHS Industry Research Advisory Group was established as a consequence. This Advisory Group is due to report in November. The future of the Biomedical Technology RLC will be considered in that time and in the light of the establishment of the Health Technology Forum.

10. Research Liaison Committees have a potentially important function but in practice their role, although useful, has been limited. "Research for Health" in 1993 proposed the creation of a Health Technology Forum. The NHS Research Taskforce (Culyer) report "Supporting R&D in the NHS" proposes a National Research Forum. It is envisaged that many of the objectives of RLCs and the proposed Health Technology Forum will now be carried forward through the National Forum and by the NHS Industry Research Advisory Group.

QUESTION 4 (A)

May we have copies of the regional R&D Plans?

11. Copies of regional R&D reports will be provided to the Committee when they become available under a separate cover.

QUESTION 4 (B)

What is to be the effect on the R&D strategy of the abolition of the regions?

12. Since its launch in 1991, the NHS R&D Strategy has combined R&D functions in the NHS Management Executive with R&D functions in the Regional Health Authorities to develop a co-ordinated, effective and responsive R&D programme for the NHS. Regional R&D networks with the NHS and universities have played a key role in identifying research requirements and in promoting the practical use of research findings. Regional Directors of R&D and their staff have made a good start consolidating and strengthening their networks in the new merged regions, while maintaining strong local input into the programme.

13. The decisions announced in "Managing the New NHS: Functions and Responsibilities in the New NHS" (July 1994) place R&D within the strategic framework arm of the NHS Executive. The report makes it clear that responsibilities for R&D will be divided between the Executive Headquarters and the new regional offices. The detailed allocation of functions is being finalised and it is anticipated that the eight Regional Directors of R&D will be formally appointed in the near future. By providing the basis for integrated working between the Centre and the Directors' offices, the new arrangements will emphasise the coherence of the national programme and strengthen the links to the users and providers of research. The more homogeneous structure and function of regional offices and reduced number of regions will be advantageous in maximising the efficiency and coordination of the R&D programme.

QUESTION 5.

How near are you to the target, set in 1991, of spending 1.5 per cent of the NHS Budget on R&D? When do you expect to reach it? Please provide detailed breakdowns of the current DH and NHS R&D budgets.

14. In November 1993 Ministers set up a Task Force, led by Professor Anthony Culyer, to review the ways in which NHS R&D is funded and how R&D in the NHS funded by other organisations is supported. The report was published on 14 September. Copies of the report have been sent to the Clerk of the Committee.

15. The report provides a series of recommendations designed to:—

- improve the targeting of funds for NHS R&D and service support for R&D funded by other bodies through better arrangements for identifying and agreeing R&D priorities;
- introduce more explicit and transparent funding for R&D and service support through the creation of a single funding stream for NHS R&D raised by a levy on health authority allocations;
- improve the management of R&D resources and accountability for their use through a variety of measures including:

    the clarification of cost categories for R&D, service costs related to R&D projects or programmes, and research facilities and staff;

    the formation of dedicated R&D commissioning units;

the regular assessment of the quality and value to the NHS of research in NHS institutions;

the development of a database of all significant R&D in the NHS, including that externally funded; and

the development of standard, published costing and accounting methodologies for R&D.

16. As the report points out, the present financial and information systems do not make it possible to quantify nationally the total NHS investment in R&D. To date, published figures for total NHS investment in R&D and service support for R&D have been broad estimates. As a result of work now being taken forward we would expect that better information will increasingly become available leading to more robust estimates of the total investment in R&D within the NHS. However, it will be important to balance the cost of collecting data with the benefits the information would give us.

17. Planned Department of Health and NHS investment in research and research related activities, including service support, for 1994–95 is as follows:

Table 2: Department of Health/NHS Research and Research Related Expenditure

1994–95, planned, £ million

Department of Health/NHS[1]	62
Service Increment for Teaching and Research (SIFTR)[2]	120
London Postgraduate SHAs (current and former)[3]	253
Non-SIFTR[4]	2
Planned Total	**437**

Note: This table excludes expenditure by health authorities and trusts. Figures are rounded.

18. When the NHS R&D Strategy started it was estimated that NHS R&D expenditure was between 0.9 and 1 per cent of gross NHS expenditure in 1989–90, or about £225 million. The figure of £437 million above suggests that NHS R&D expenditure has risen to 1.2 per cent if the "excess cost" provision for the London Postgraduate SHAs is excluded.

19. It will be necessary to review the position on NHS R&D expenditure as better information becomes available.

QUESTION 6.

Is the Strategy confined to England? What are the equivalent arrangements for Scotland, Wales and Northern Ireland?

20. The NHS R&D strategy launched in 1991 in "Research for Health" covers the NHS regions within England. The other Health Departments have been kept closely in touch with developments, and each of the Departments has taken steps to develop plans appropriate to the needs of their populations.

21. At the same time the work to promote the NHS strategy in England has also been influential in developing thinking within the other home countries. For example, the Report of the Taskforce on the Strategy for Research in Nursing, Midwifery and Health Visiting and the Therapists' has been influential in the preparation of reports on the position of nursing research in Scotland, Wales and Northern Ireland.

Scotland

22. In Scotland, a "Research and Development Strategy for the NHS in Scotland" was launched in October 1993. The strategy, led by the Chief Scientific Officer of the Scottish Home and Health Department, identifies specific headings under which health research might usefully have been conducted.

23. Work on implementing the results of R&D in practice is receiving a high priority under the direction of an Implementation Group led by a Health Board General Manager and comprising purchasers and providers. The objective is to ensure that decision making in the NHS in Scotland is well founded, and that the service becomes a discriminating user of scientific advances and new styles of management. R&D evidence

---

[1] "Forward Look of Government-funded Science, Engineering and Technology 1994", HMSO, 1994.

[2] Total SIFTR = £424 million + £58 million capital charges. Support for research assumed to be 25 per cent of this.

[3] Six of the eight SHAs were approved as 4th wave Trusts from 1 April 1994. Strategies for the Eastman and the National have still to be approved. Central support for "excess costs" = £52 million (reducing gradually to zero by 1997–98; there will be a compensatory increase in market funding distributed to purchasers); central support for clinical services necessary to sustain approved R&D programmes = £201 million.

[4] The Non-SIFTR scheme supports research in hospitals which are neither SHAs nor (because they do no undergraduate teaching) eligible for SIFTR.

will be made available to underpin decisions at all levels and in all sectors of the NHS—to inform policy, the development of new services, the commissioning and evaluation of existing services, and to support routine clinical and management practice.

Wales

24. The framework for R&D in Wales was set out in "Sharpening the Focus: Research and Development for NHS Wales" which was published in December 1992 by the Welsh Office Health Department.

25. An Office of Research and Development was established in May 1993. It has a key role in developing and implementing a strategic approach to R&D to achieve the goals set out in "Sharpening the Focus". The Office works closely with health service clinicians and managers together with the health research community in Wales and further afield, to identify and address research priorities. This work is supported by a Research and Development Forum which brings together a wide range of clinical, scientific and health economics experience and skills.

26. NHS Wales has allocated funds to support research and development directed towards better health, better services and choice, and better value for money. The Research and Development Forum has identified an initial series of research priorities and the Office of R&D is commissioning work in these areas.

Northern Ireland

27. The NHS R&D strategy in England has common themes which are embraced by the aims and objectives of the R&D strategy of the Department of Health and Social Services (DHSS) in Northern Ireland.

28. In 1993 the DHSS published a consultative paper entitled "A Strategy for Research and Development in the Health and Personal Social Services in Northern Ireland". This paper proposed an outline strategy for R&D, taking account of the NHS reforms and relevant Northern Ireland legislation. In particular, the strategy recognised the need to monitor and evaluate the impact of organisational reforms; to develop capacity to assess population needs for services; to improve the targeting of service provision; to assess the appropriateness, quality, standards, cost-effectiveness and outcomes of services and intervention; and to monitor progress towards set targets.

29. These considerations are underscored by the two main aims of the R&D Strategy for health and personal social services in Northern Ireland:

- to ensure that improvements in health and well-being are brought about by the influence of high quality research on professional and management practice.
- to help foster and develop health and social services research capacity in Northern Ireland.

Question 7

What is the place of public health research in the EC Fourth Framework programme for R&D?

30. The EC's Fourth Framework Programme on Research and Technology Demonstration (FP4) will run from 1995 to 1998. The programme as a whole has a budget of 12.3 billion ecu ($\approx$ £9.2 billion), and within that there is a programme on R&D in the field of Biomedicine and Health (known as BIOMED), with a budget of 336 million ecu ($\approx$ £252 million). BIOMED will fund a comprehensive programme of research covering the areas of pharmaceuticals, biomedical technology and engineering, brain, diseases of major impact, human genome, public health and biomedical ethics. Departmental and MRC officials are working together to ensure that, as far as possible, research programmes funded through BIOMED are in keeping with the UK priorities for medical research.

31. A number of different research activities will be supported under FP4 and its individual programmes such as BIOMED. Public health research is likely to be conducted through concerted action, or supporting initiatives which bring together researchers doing similar work in different countries, while the research itself is funded within each country. This will allow for the most effective use of the funds available to provide added value from the Community's involvement.

32. The clinical research into major diseases and the public health research elements of the BIOMED programme have more relevance now the Community has a stronger and more focused role in promoting public health. Article 129 of The Treaty on European Union provides for the EC to contribute to a high level of human health protection. It states that

> "community action shall be directed towards the prevention of diseases . . . by promoting research into their causes and their transmission, as well as health information and education".

33. The Health Council will be adopting programmes of Community action under this Article to encourage member states to exchange information and coordinate their policies for the prevention of major diseases. The research supported by the Community through the BIOMED programme should help to give

a sound base for this Community action. The Health Council in recent Resolutions has stressed the need for effective coordination to ensure that the Community's research activities in the public health field and its specific public health programmes are aiming at the same goals.

QUESTION 8

Have other countries emulated aspects of the NHS R&D Strategy?

34. There has been considerable interest in the NHS R&D strategy in Europe, North America, Australia, New Zealand, Israel and the Far East. Interest has focused in particular on the Information Systems Strategy and the Cochrane Collaboration, on Health Technology Assessment, and on the strategy for nursing research. The consequences of this interest are detailed below.

Information Systems Strategy (ISS)

35. All three components of the ISS—the Cochrane Centre, the Centre for Reviews and Dissemination, and the Project Register System—have attracted international interest.

36. The UK Cochrane Centre which facilitates and coordinates systematic, up-to-date reviews of randomised controlled trials of health care is part of the **Cochrane Collaboration,** an international network of reviewers who combine to form collaborative review groups to focus on specific health issues. Other Cochrane Centres within the Collaboration are in Canada, the USA (Baltimore), Scandinavia (Denmark), Australia, Italy and (planned) Germany. The UK Cochrane Centre was the catalyst for those of other countries. The UK is now gaining substantially from the worldwide activity supported by the Cochrane Collaboration.

37. The **Centre for Reviews and Dissemination** (CRD) is a leading member of the International Network of Agencies for Health Technology Assessment (INAHTA), a network of agencies undertaking systematic reviews and analyses on the effectiveness of health care interventions. The Centre is taking the lead in developing international standards for reviews and a database of high quality reviews.

38. A number of countries have expressed interest in developing systems analogous to the NHS Project Registers System—a distributed database of health research funded by a range of NHS, Departmental and other bodies.

Health Technology Assessment (HTA)

39. There has been widespread interest in the last year in the speed, scale and support for HTA within the NHS for this key element in the R&D programme. Other countries are seeking to emulate the systematic approach to setting priorities for HTA (Departmental officials are leading a European working group on this), and the progress made in linking the outputs of HTA to clinical and managerial decision making in the NHS through the NHS Executive's support for evidence-based guidelines and other work on improving clinical effectiveness. Of particular interest have been the systems developed to respond rapidly to important new technologies and to advise purchasers of new technologies currently under assessment.

Nursing Research

40. The Council of Europe Committee of Experts on Nursing Research was sent copies of Research for Health and the Report of the Taskforce on the Strategy for Research in Nursing, Midwifery and Health Visiting. It is understood that both these Reports have been influential in the preparation of a paper being prepared by the Committee for submission to Council of Europe Health Ministers in 1995. The Report was also circulated to WHO in office in Copenhagen and in Geneva, and has been considered by a Nursing Sub Committee in Geneva.

International Conference

41. Through the R&D Directorate, the Department is sponsoring an international conference on the "Scientific Basis of Health Services" which is being held on 2–4 October 1995 in London. This event will explore how different countries use R&D to inform public health and health services as they attempt to maximise the benefits of their health spending programmes. This occasion will provide an important opportunity for other countries to learn about the work of the NHS R&D strategy.

QUESTION 9.

Please tell us about the Locally Organised Research Scheme.

42. The operation of the Locally Organised Research Scheme (LORS) was governed by a Health Circular from the former DHSS in 1988. This prescribed the role and composition of Research Committees to administer LORS. It also required Health Authorities to make annual financial returns to the Department.

43. LORS was intended to complement research funded by the MRC and Health Departments. Its primary aims were to encourage critical enquiry and evaluation of local services and service delivery, and to assist

workers in all branches of the health professions to develop personal skills and experience in research. Funding was provided in response to research proposals made by researchers and health professionals.

44. All RHAs continue to provide funds within the NHS R&D strategy to support research projects put forward by researchers as well as the priority-led R&D which forms the keystone of the programme. In some cases these are still separately managed; in others their administration has been integrated with other RHA support for research. Following the publication of Culyer report[1], these funds will become part of the single funding stream for NHS R&D.

45. As noted in the reply to question 4 above, the precise allocation of R&D functions between the new regional offices and the Executive Headquarters is still under discussion. The intention, however, is to retain a capacity within the NHS to respond to proposals for critical enquiry and evaluation of local services and service delivery.

46. Work is in hand to review the current capacity to undertake high quality research needed by the NHS and to consider how shortfalls in the capacity and in the ability of NHS decision makers to use research can best be addressed. The role of responsive research grants in developing these capacities will be given careful consideration.

QUESTION 10. *What is the role of the Director of R&D in respect of DH R&D outside the NHR R&D programme?*

47. The role of the Director of Research and Development (DRD) covers all aspects of the research and development interests of the Department, including the NHS Executive. DRD is supported in this task by the Department's Research and Development Division (RDD).

48. The DRD is directly responsible for the centrally commissioned programme (CCP) of health and personal social services which deals with issues of policy and central operational strategy. The purpose is to provide a reliable and relevant knowledge base for health services policy, social services policy, and central policies aimed at achieving health gain for the population as a whole. Research priorities are developed on the basis of a strategic view of the research needs of the Department. A substantial element of the CCP progamme is carried out by the 13 Department-funded units based mainly at the universities. Expenditure on the CCP was estimated at £23.6 million in 1993-94[2].

49. As chairman of the Departmental Research Committee, the DRD has oversight of, and accountability on behalf of the Secretary of State for other Department of Health-sponsored research activity whether this is conducted within the Department or through the Non-Departmental Public Bodies. Research conducted outside of the RDD includes a major programme of radiation protection. A total of £6.5 million of research is commissioned outside RDD[3].

50. The Department's sponsored Non-Departmental Public Bodies (NDPB) include the Public Health Laboratory Service and the National Radiological Protection Board. The Department sponsored NDPB research to £24 million in 1993-94[4].

51. The Department issued a Code of Practice for the commissioning and management of research and development in June 1993. This Code emphasises the importance of policy relevance, transparency, accountablility, quality and value for money. A copy of the Code of Practice is attached (*not printed*).

QUESTION 11. *Does the DH produce an R&D report, other than "Research for Health"? If so, please supply a copy.*

52. The Department published "Research for Health" in June 1993 which gave a progress report of the NHS R&D strategy and of the Department's R&D programme. This document is the only current report which provides an overview of all R&D programme developments sponsored by the Department. It updated an earlier publication of the same title, published in September 1991 which set out the framework for the NHS R&D strategy. The first of a regular series of R&D plans will be published in 1995.

---

[1] "Supporting Research and Development in the NHS" 1994 (HMSO)

[2] Forward Look of Government Funded Science, Engineering and Technology 1994, Statistical Supplement (HMSO)

[3] ibid.

[4] ibid. Full details of the research expenditure of the DH-NDPBs are given in the 1994 Forward Look

53. The full list of titles about the NHS R&D strategy published by the Department are listed below:

"Research for Health" (September 1991)
"NHS Research and Development Strategy—Guidance for Regions" (September 1991)
"NHS Research and Development Strategy—Finance Guidance for Regions" (April 1992)
"Assessing the Effects of Health Technology Assessment" (October 1992)
"Report of the Taskforce on the Strategy for Research in Nursing, Midwifery and Health Visiting" (May 1993)
"Research for Health" (June 1993)
"R&D Priorities in Relation to the Interface Between Primary and Secondary Care" (May 1994)
"Standing Group on Health Technology, 1994 Report" (July 1994)
"Supporting Research and Development in the NHS" (The Culyer Report) September 1994 (HMSO)

54. A report on Departmental research and development, including a detailed listing of the projects of the centrally commissioned programme of health and personal social services will be published at the beginning of 1995.

QUESTION 12. *Please list the members of the DH Departmental Research Committee*

55. The Departmental Research Committee (DRC) advises the Secretary of State on research and development policy in the field of health and personal social services policy and on operational matters pertaining to Government R&D policy. The members of the DRC are as follows:

Professor Michael Peckham (Director of Research and Development, Chairman)
Dr Kenneth Calman (Chief Medical Officer)
Mr Alan Langlands (Chief Executive, NHS Executive)
Mr Strachan Heppell (Deputy Secretary, Health and Social Services Group)
Dr Jeremy Metters (Deputy Chief Medical Officer)
Dr Graham Winyard (Medical Director, NHS Executive)
Mr Jo Pilling (Deputy Secretary, Departmental Resources and Services)
Mr Herbert Laming (Chief Inspector, Social Services Inspectorate)
Mrs Yvonne Moores (Chief Nursing Officer)
Mr Clive Smee (Chief Economic Adviser)
Professor Gilbert Smith (Deputy Director of Research and Development)

56. Representatives from the other UK Health Departments of Scotland, Wales and Northern Ireland attend the DRC as observers.

QUESTION 13. *Does the Chief Medical Officer have anything to do with R&D?*

57. In his capacity as Chief Medical Adviser to the Government, the Chief Medical Officer (CMO) has a central role in developing and identifying issues related to health, notably in the Department of Health, but in other Departments of State including MAFF, DOE and Transport. The development of intelligence systems and networks to assist with this, are part of this function.

58. The CMO has an important role in developing the R&D policies of the Department as a member of the Departmental Research Committee which oversees the development of Departmental research priorities. He is a member of the Medical Research Council, with the Director of Research and Development and CMO Scotland, and part of the annual Health Department (HD) Stocktaking team which reviews the HD/MRC Concordat. The Concordat is designed to develop and maintain an effective partnership for the promotion, funding and management of medical research in the UK. A Deputy CMO attends meetings of the Central Research and Development Committee (CRDC) which provides advice on the development of the NHS R&D strategy.

59. The CMO is represented through the Department's network of medical officers in the shaping of research policy in individual policy areas and the day to day development of many individual research projects sponsored by the CCP. Medical officers together with RDD and policy colleagues represent the Department's interest in many different arenas and organisations.

60. The report "Public Health in England: Role and Responsibilities of the Department of Health and NHS" emphasises the close working between the R&D and public health functions to help support R&D related to public health topics. Within the Executive, RDD staff work closely with the Health Care Directorate (headed by Dr Winyard, DCMO) on the development of implementation work to promote clinical effectiveness in the NHS.

61. The increasing importance of the outcome of care is reflected in the need to ensure that clinical practice is audited and that it benefits from research and development. Through the Clinical Outcomes Group (chaired jointly with the CNO) the research implications are identified, in association with RDD, and translated into practice.

62. The CMO oversees the Department's medical education and training arrangements which have strong and growing links with the R&D strategy. The CMO and DRD are both members of the Steering Group on Undergraduate Medical and Dental Education and Research (SGUMDER), established by the Department of Health and the Department of Education in 1987.

QUESTION 14. *Who is the NHS Director of Trials, and what does he do?*

63. Negotiations are in hand which are intended to lead to the establishment of a National Director in the NHS R&D programme, with responsibility for trials. The Director's role would be to work with the professions, research councils and research funders to promote the rapid establishment of high quality, large trials addressing important questions.

QUESTION 15. *Please supply brief details of the Cochrane and York centres, including addresses. Would it be appropriate for the Committee to visit them?*

64. The **UK Cochrane Centre (UKCC),** established in October 1992 under the Directorship of Dr Iain Chalmers, facilitates and co-ordinates systematic reviews in the specialised area of randomised controlled trials of healthcare. The Cochrane Collaboration, an international network, deals with systematic reviews of all reliable evidence on the effects of healthcare.

65. The outputs by the end of 1994 will include data modules in four areas of healthcare, including pregnancy and childbirth.

66. The **NHS Centre for Reviews and Dissemination (CRD),** based at the University of York under the Directorship of Mr Trevor Sheldon, was established in December 1993 to provide the NHS with key facts from research into effectiveness of treatments and the delivery and organisation of health care. CRD core staff commission and support expert reviewers, ensuring that reviews meet quality criteria. Close co-operation is maintained with the UK Cochrane Centre and with others.

67. CRD produce user-friendly materials, based on research findings for dissemination to the NHS, ensuring that materials meet the needs of users of whatever functional role or professional background. In the longer-term, CRD will provide an enquiry-based service.

68. The outputs of CRD to date include commissioned reviews, completed or underway, in nine subject areas. CRD disseminates the well-known Effective Health Care Bulletins and will be producing further issues of this series and developing new series. The CRD has taken over responsibility for a "Register of Economic Assessments of Healthcare" formerly known as the Database of Cost Effectiveness Studies. This has recently been issued to the NHS in pilot form. CRD will be evaluating responses to it and further developing the Register.

69. The UK Cochrane Centre's address is Summertown Pavilion, Middle Way, Oxford OX2 7LG. CRD's address is NHS Centre for Reviews and Dissemination, University of York, Heslington, York YO1 5DD.

70. UKCC was opened in November 1992 by Mr Tom Sackville and is now well established; it would be appropriate for the Committee to visit the Centre.

71. The CRD has been established for less than a year and is still recruiting its core staff. A discussion with Mr Sheldon, the CRD Director, and Professor Richard Lilford, of Leeds University, the Chair of its Steering Group, might be more appropriate than a visit to the centre by the Committee.

QUESTION 16. *Please supply a list of Regional directors of R&D*

72. The Regional Directors of R&D (RDRDs) in post are:

Professor Andrew Haines, North Thames RHA
Professor Terry Stacey, South Thames RHA
Dr Pat Cooke, Trent RHA
Professor Stephen Frankel, South and West RHA
Professor Richard Himsworth, Anglia and Oxford RHA
Professor Alexander McNeish, West Midlands RHA
Professor George Alberti, Northern and Yorkshire RHA
Professor Alasdair Breckenridge, North West RHA

QUESTION 17. *How is it known that service support accounts for two-thirds of NHS R&D spending (Culyer report 3.8)? Can you put money values on this?*

73. The Department's latest estimate of Departmental and NHS expenditure on R&D and service support for R&D was set out in an answer to question 5.

QUESTION 18. *Commercial funders pay full costs to the NHS. How are these assessed? Do they include service support costs?*

74. It is the Department's policy that commercial research funders should pay the full costs of research they undertake in the NHS including any excess service costs. No public funds are made available to health care purchasers or providers to support commercial research.

75. The internal patient care market provides the incentive for health care providers to recover full costs from commercial research funders—if providers fail to do so, their prices for patient care will be less competitive. The assessment of costs, and actual cost recovery, are matters for providers to negotiate with commercial research funders.

76. Guidance on costing R&D including commercially funded R&D was issued to providers in October 1993.

QUESTION 19. *To what extent does the Culyer report apply to, involve or affect Scotland, Wales and Northern Ireland?*

77. The principles set out in the Culyer report for improved management and targeting of R&D in the NHS in England are being looked at by the Scottish Office Home and Health Department with a view to their application to the Scottish NHS.

78. Although the Culyer report does not strictly apply to Wales, it will have a bearing on how we take forward research and development in the principality. Welsh Office officials are liaising with the Department of Health (and other UK Health Departments) on the action being proposed in England to develop arrangements and build on the report's recommendations. Recommendations will be put to the Welsh Office Ministers later this year on what action should be taken in the light of the Culyer report.

79. The Department of Health and Social Services, Northern Ireland will be considering the implications of the Culyer report for Northern Ireland at the next meeting of its Departmental Research Committee.

QUESTION 20. *Please give as many examples as you can of what might constitute "service support". How can service support be distinguished from the ordinary indirect costs of a research project?*

80. Attempts to devise a possible "menu" of service items which form a part of or facilitate research activities and may lead to excess service costs have so far been unable to overcome problems of definition particularly in relation to the funding of clinical trials. It is the Department's practice, for major clinical trials, to consider each case on its merits. We recognise that there is a need for more work on the attribution of costs between external research funders and the NHS.

QUESTION 21. *Will implementing the Culyer report involve amending section 51 of the National Health Service Act 1977?*

81. No.

QUESTION 22. *How significant are clinical services provided to the NHS at the expense of other funders of R&D—the other side of "knock for knock"?*

82. The Department does not collect this information. The Committee may wish to consult external research funders.

QUESTION 23. *Please give a layman's account of the position of consultants working in both an NHS hospital and a university department. Is there a joint DH-DFE working party, or something similar, on this?*

83. Universities and teaching hospitals necessarily work very closely together. NHS consultants are involved in teaching students, whilst university clinical staff are involved in delivering NHS services to patients. Universities and the NHS have not usually engaged in quantification and cross-charging when the staff of one perform duties for the other. The staff time involved has usually been treated as part of "knock-for-knock", an informal cost sharing arrangement.

84. All NHS consultants employed on the national terms and conditions of service must have a job plan agreed with the general manager responsible for the day-to day management of their contracts. The job plan must include the main duties and responsibilities and a schedule of the fixed commitments of the post, including information on the clinical, teaching, research and administrative elements. Contracts are drawn up between the employer and employee and it is for them to reach mutual agreement.

85. Clinical academic staff are university employees but they have honorary NHS contracts which allow them access to patients for teaching, research and service purposes. Employers are encouraged to recognise the particular needs and responsibilities of these staff. Employers should be prepared to allow more flexibility in the way in which NHS commitments are fulfilled by members of academic departments, for example for the purpose of a research programme. The number of fixed NHS commitments should be agreed by the consultant and the general manager in consultation with the medical school dean or head of the academic department in the context of the overall commitments of university staff.

86. There is no joint DH/DFE group looking specifically at this issue. There is, however, a group entitled the Steering Group on Undergraduate Medical and Dental Education and Research which was set up jointly in 1987 by DH and DFE. Its membership includes the MRC, AMRC, CVCP, HEFCE and its role is to advise the Government on how arrangements for the planning and funding of medical and dental education and research could be improved. Among the many issues the Steering Group has considered, and which it continues to monitor, have been consultant contracts, with respect to teaching and research commitments and knock-for-knock.

QUESTION 24. *What is meant by the concept of "research beds"? Is there a country where such a system exists?*

87. The idea of research beds (as proposed in some evidence submitted to Culyer) is that beds should be set aside exclusively for research purposes and the total costs of patient care associated with these beds borne other than by purchasers of health care.

88. We are unaware of any system of "research beds" in other countries, or of any other countries using this idea.

QUESTION 25. *What was the review of SIFTR?*

89. A framework for a review of the Service Increment for Teaching and Research (SIFTR) was agreed by the Steering Group on Undergraduate Medical and Dental Education and Research in October 1990. This work was undertaken in three stages:

Stage 1—Exploration of a research indicator

90. This stage explored whether information on the extent and cost of research could be used to develop a reliable and meaningful way of taking variations in research activity into account in allocating SIFTR to RHAs. A report was produced in October 1991 which recommended a new multivariate statistical analysis of hospital costs.

Stage 2—Analysis of 1991–92 arrangements

91. The second stage examined how the arrangements for sub-regional distribution of SIFTR operated in 1991–92, and what progress had been made in plans for 1992–93 towards implementing the recommendations in the Second Report of SGUMDER (June 1990). Two reports were produced which concluded that while RHAs were making progress, they still had some way to go towards implementing these recommendations.

Stage 3—Consolidation and looking to the future

92. The third stage pulled together the most significant findings of the earlier stages; discussed the coverage of SIFTR and its place in the post-White Paper NHS; reviewed the impact of developments in costing, pricing and case mix definition; and made recommendations on the information needed to make informed judgements about the right level of SIFTR, or any variation on it. A report was produced in September 1992.

93. The multi-variate analysis of hospital costs which SGUMDER recommended was carried out during 1993–94.

94. A report on the findings of this work was considered by SGUMDER on 19 October in the context of the recommendations of the report on "Supporting Research and Development in the NHS" (the Culyer report).

Letter from Professor Michael Peckham

1. In preparation for its examination of witnesses, the Committee asked for copies of Regional Health Authorities' R&D plans. These will be submitted to the Committee directly by regions once they have been formally approved and published by the relevant RHA. Most should be available by the end of November.

2. I am taking this opportunity to provide the Committee with other material germane to the consideration of regional plans. Enclosed with this letter are copies of:

- *Research for Health* (June 1993) (*not printed*)
- A paper entitled *R&D in the New NHS*
- A summary of the main achievements in the NHS R&D programme and related areas
- A paper entitled *R&D in the Department of Health*

3. **R&D in the New NHS** describes how R&D will be organised within the framework which Ministers have agreed for the future organisation and management of the NHS. It also indicates where and how the organisation of R&D functions will need to take account of the recommendations in the report of the NHS R&D Task Force *Supporting Research and Development in the NHS.* **R&D in the New NHS** is intended to be read alongside *Research for Health (1993)* and not to replace it.

4. My staff in the Department of Health's Research and Development Division have responsibilities for R&D to support the full range of the Department's work. The organisation of the Department has recently been reviewed by Mrs Terri Banks whose report (July 1994) recommended that DH should work as one Department with three main business areas—health care (including the NHS Executive), social care and public health. The attached paper on **R&D in the Department of Health** indicates how RDD will support all three business areas and other strategic work on R&D. The NHS R&D programme is, of course, a key part of this work and the paper on **R&D in the New NHS** (which I am enclosing with this note as a separate document, given its direct relevance to the Committee's enquiry) forms Annex B to the paper on Departmental R&D.

5. Following the introduction of the R&D strategy, Regional Heatlh Authorities published annual R&D plans in 1992 and 1993. As part of the final stages of the NHS reforms, the NHS Executive regional offices came into existence on 1 April 1994 and from the same date the number of RHAs was reduced to eight, sharing common boundaries with the regional offices. Subject to the consent of Parliament, RHAs will be abolished with effect from 31 March 1996. In their transitional capacity (as RHA/regional offices) the regions will each publish an R&D plan again this year (which RHAs will send directly to the Committee). Thereafter, we intend to produce a single, annual R&D plan in line with the NHS Executive's new "single centre" mode of working. The first consolidated R&D plan for the NHS will appear in 1995.

6. I hope that this information will be helpful to the Committee.

27 October 1994

RESEARCH AND DEVELOPMENT IN THE NEW NHS

1. Introduction

1.1 The NHS R&D strategy was launched in April 1991, followed by the publication of the strategic statement *Research for Health* in September 1991. A second edition of *Research for Health,* published in June 1993, reported progress in developing management structures and outputs and in delivering change. Regional Health Authorities' R&D plans published in 1992 and 1993 have given further details of local arrangements and achievements.

1.2 In July 1994 the NHS Executive published *Managing the New NHS: Functions and Responsibilities* setting out the framework agreed by Ministers for the future organisation and management of the NHS. The purpose of this paper is to explain how R&D will be organised within the new NHS described in the Executive's publication. It describes the functions which regional offices and the Headquarters of the NHS Executive will undertake to support the NHS R&D strategy. It is intended to be read alongside, and not to replace, *Research for Health (1993)* and to accompany RHAs' 1994 R&D Plans.

1.3 In September 1994 the report *Supporting Research and Development in the NHS* was published under cover of Executive Letter *EL(94)68.* The report was the work of an independent Task Force chaired by Professor Anthony Culyer. Its recommendations have been welcomed by Ministers as providing a basis for supporting research and development in the NHS into the next century. Work is now in hand to take forward the recommendations in partnership with the Universities, the Research Councils, Charities and other organisations which support research in the NHS. The arrangements described in this paper for managing R&D will be updated in 1995 in the light of this work.

2. Aim, Objectives and Key Functions

2.1 The aim of the NHS R&D Strategy is to secure a knowledge-based health service in which clinical, managerial and policy decisions are based on sound and pertinent information about research findings and scientific and technological advance. This provides the basis for maximising the effectiveness, efficiency and appropriateness of patient services.

2.2 The Functions and Manpower Review of the NHS, and particularly the work of Functions Review Group 1, have helped to clarify the specific goals and objectives of the R&D strategy within the broader strategic framework now being developed for the NHS.

2.3 The goals and objectives of the R&D strategy are set out in Annex A. They give rise to six key functions that were not undertaken systematically prior to the introduction of the R&D strategy. These are

(i) to identify NHS requirements for research and science-based knowledge;

(ii) to ensure that knowledge relevant to NHS requirements is forthcoming, in particular by

- making other funders aware of NHS needs
- commissioning and managing NHS-funded R&D
- supporting research in the NHS sponsored by other funders

(iii) to ensure that information about research-based knowledge and technological advances is available to decision makers;

(iv) to promote the use of information about research-based knowledge;

(v) to promote an evaluative culture;

(vi) to develop and evaluate the R&D strategy.

These functions are described in more detail in Annex B.

2.4 Table 1 summarises how responsibilities for these functions are now to be distributed between the Executive's Headquarters and its regional offices, health authorities, consortia of health authorities, patient care providers and universities and others who undertake research. The next section of this paper considers the human resources which will be called upon in each of these locations to support the R&D strategy. Responsibilities within each function are then described in more detail.

3. Human Resources

3.1 Within the NHS Executive, staff to support the R&D strategy are located in the Headquarters and each regional office. Within Headquarters, the Department of Health's Director of Research and Development (DRD) is a member of the NHS Executive Board. He is supported by an NHS Executive Branch of the Department's Research and Development Division (RDD). RDD works as an integrated division within the Department with other Branches of the Division contributing to the development and implementation of the NHS strategy as well as other Departmental research work. For this reason, a number of responsibilities for R&D which might be expected to be assigned to "NHS Executive Headquarters" are in fact assigned more broadly to "RDD" in the following sections of this paper. (The relationship between the NHS R&D programme and other Departmental research is described in more detail in section 10 of this paper.)

3.2 Each regional office will include a Regional Director of Research and Development (RDRD) as part of its regional top management team. The RDRD will be supported by regional office R&D staff who will work closely with those responsible for education and training and with other staff reporting to the Directors of Public Health, Performance Management and Finance.

3.3 Staff in the NHS executive are responsible for coordinating and managing work within the R&D strategy. But the success of the strategy in identifying an R&D agenda for the NHS and ensuring that the findings of research are translated into improved services and value for money depends crucially upon the work of staff throughout the NHS. All health authorities and trusts will need to be actively involved in identifying research needs and promoting the use of research findings. It is anticipated that authorities and trusts will appoint an individual to lead the organisation's work relating to R&D. Those working in primary care also have a key role to play in identifying NHS R&D needs and in implementing findings. RDD and regional office staff are developing training packages to help NHS staff understand the importance of R&D to their work.

3.4 The success of the R&D strategy also depends crucially upon the research community—and particularly its leaders—within and outside the NHS. Without their active support and involvement it is not possible to set a practicable research agenda, take it forward or make sense of its findings.

4. Identifying NHS Requirements for R&D

4.1 The NHS R&D strategy is needs-led and places emphasis on identifying the needs and priorities of the service for research-based information. The identification of needs and priorities that are both relevant to decision makers in the service and amenable to research is not straightforward. Without an understanding of research, questions will be posed that are unresearchable. And without an understanding of the needs and perspective of decision makers research questions may reflect the interests of researchers more than the needs of the service. NHS decision makers need to be brought together with researchers in a managed process to ensure that the problems facing the service are correctly identified and translated into feasible research questions.

4.2 Bringing the NHS and the research community together to identify NHS research needs and priorities is one of the key challenges facing the R&D strategy. Considerable progress has already been made through the development in regions of R&D networks and committees and through the Central Research and Development Committee for the NHS (CRDC) and its Advisory Groups. There is a need, however, to develop this further and to strengthen links to a broader college of NHS decision makers.

R&D Networks

4.3 RDRDs and their staff in regional offices will continue to develop and support R&D networks in which staff nominated by health authorities and trusts meet with research workers and those working on professional education and audit to discuss their needs for information and to consider where R&D may be able to help. The R&D networks will feed into the regional R&D committees described below.

4.4 R&D networks also play a crucial role in promoting the uptake of R&D findings in the NHS (see paragraph 7.2 below) and in developing links between the NHS and the research base.

Regional R&D Committees

4.5 Each RHA currently has a regional R&D Committee. RDRDs will reconstitute these committees to reflect the new regional boundaries and to strengthen input from those in the NHS who use, or should use, research-based information. The regional R&D Committee will identify the research needs of the NHS in the region. It will base its advice upon the input from the regional R&D Network(s) and will work with the Network(s) to promote widespread participation in, and ownership of, the R&D strategy in the region. The regional R&D Committee will also advise, and oversee work, on promoting the uptake of R&D findings (see paragraph 7.2 below). Its role is distinct from the regional peer review groups and commissioning groups described in paragraphs 5.5 and 5.6 below.

4.6 General terms of reference for regional R&D committees are at Annex C.

4.7 The RDRD in each office will select the members of the regional R&D Committee from amongst those involved in the R&D Network(s) and from other key players. The RDRD will either chair the Committee or appoint an appropriate chair from amongst its members. The balance of membership will reflect the characteristics of the region such as the number of health authorities and trusts, universities and medical schools, other relevant research capacity, local social service provision and industry. Size will vary, but the Committee will ideally have no more than 20 members. Members will be appointed for their personal contribution and understanding of the sector to which they belong. They will *not* represent specific organisations. In particular, members drawn from health authorities and trusts will be expected to represent the perspective of these classes of organisation and not defend or promote the interests of their own authority or unit. R&D staff in the regional office will provide the secretariat for the R&D Committee.

Central Research and Development Committee for the NHS (CRDC)

4.8 The Central Research and Development Committee for the NHS (CRDC) will continue to advise on NHS priorities for R&D and will continue to seek guidance on these from expert advisory groups bringing together NHS clinical and management staff, research workers and those using services. Advisory groups will continue to consult widely. Input from the NHS will be strengthened by linking the work of advisory groups directly to the R&D networks and R&D committees in regions. NHS members of advisory groups will be selected from regional networks and R&D committees. R&D committees will be formally consulted by advisory groups at the start of their work and asked to comment on draft reports before they are submitted to the CRDC.

4.9 The framework and cycle within which NHS R&D priorities are currently considered will itself to be reviewed and developed to ensure that it provides a sensible basis both for reviewing the needs of the service and for organising research. Input to this work will be sought from regional R&D committees.

4.10 Consideration is being given to the recommendations in the Culyer report about the future role of the CRDC and the need for a national forum. Meanwhile, the CRDC will continue to advise on all aspects of the development and implementation of the NHS R&D Strategy as well as on R&D priorities.

4.11 RDD is responsible for supporting the CRDC and ensuring support for its advisory groups. RDD will also manage the review of the framework for R&D priorities.

5. Ensuring that Knowledge Relevant to NHS Requirements is Forthcoming

Making other funders aware of requirements

5.1 The NHS cannot itself fund all the research it needs. It will continue to depend upon additional relevant national and international work. This includes work supported by the Medical Research Council and other research councils, the Wellcome Trust and other research charities, the universities and industry. RDD will be responsible for ensuring that NHS research needs and priorities relevant to the remits of other funders are made known clearly and discussed with these organisations. RDD will also continue existing work to promote international collaboration and information exchange in health technology assessment, meta-analysis and other areas of health research.

Support for other funders' research in the NHS

5.2 RDD will lead discussions within and outside the NHS to take forward the recommendations in the Culyer report. Work on specific topics will be progressed by teams bringing together staff from NHS Executive Headquarters, regional offices, the field and other interested organisations. Regional offices with substantial numbers of London Postgraduate Special Health Authorities and/or teaching trusts will have a particularly important role to play.

5.3 Responsibilities in the NHS Executive Headquarters and regional offices, the wider Department of Health, trusts and elsewhere for any new arrangements that are agreed upon will be announced in due course. Meanwhile, regional offices will be responsible for the local allocation and management of the R&D component of SIFTR funds and Headquarters will continue to promote coordinated arrangements for multi-centre trials and other studies.

NHS-funded research

5.4 NHS funding for the direct costs of research comprises both response-mode funding and a commissioned programme of work addressing the needs and priorities of the NHS for research. The commissioned programme itself comprises three components: a strategic needs-led programme of work addressing priorities identified by the CRDC; a complementary needs-led programme addressing important issues identified by regional R&D committees but not formally designated by the CRDC as priorities; and a programme of longer term support for research units and centres working on, and able to respond to, questions arising from R&D committees and/or the CRDC. Figure 1 illustrates these sub-divisions of NHS funding for R&D.

5.5 **Response-mode funding** will continue to be managed by regional offices in the same spirit as the Locally Organised Research Scheme (LORS) which was governed by a Health Circular from the former DHSS in 1988. Regional offices will consider grant applications from those working in the region. Funding decisions will be made on the basis of advice from a regional peer review committee appointed by the RDRD and will reflect the scientific quality of the work proposed and its value to the NHS (defined broadly and not simply in terms of disease incidence). The regional peer review committee is not the same as the regional R&D committee which is not constituted to advise on the scientific merit of proposals. Funding decisions will have regard to, but not constrained by, the needs and priorities identified within the R&D strategy.

5.6 The **needs-led programme** addresses important issues identified by regional R&D committees but not formally designated by the CRDC as priorities. This work will continue to be commissioned and managed by regional offices. RDRDs will seek advice on the scientific design and practical utility of the work to be commissioned from their regional peer review committee or from other appropriately convened advisory structures.

5.7 The **strategic needs-led programme** of work addresses priorities identified by the CRDC. At present this is coordinated from Headquarters where the budget is held. Some work is commissioned and managed by Headquarters staff under the professional direction of Programme Directors. Other work is commissioned and managed under contract through the R&D directorates of RHAs under the direction of the RDRD. In all cases, advice on scientific quality and relevance comes from an independently chaired commissioning group. These arrangements will continue but will be reviewed in the light of the developing workloads and staffing arrangements in RDD and regional offices.

5.8 Some RHAs currently provide longer-term **support for research units and centres.** Responsibility for letting and managing contracts for research units and centres will move in future to RDD to ensure consistent standards of competition and quality across the whole of the R&D Strategy and coordination with support for units in the Department of Health's Centrally Commissioned Programme of research (see paragraph 5.10 below).

5.9 It is appropriate that a strategic programme addressing nationally identified priorities should be coordinated by RDD and that programmes addressing locally identified needs should be commissioned and managed in regional offices. However, this presents a challenge for coordination. Many of the needs identified by regional R&D committees will be taken up as CRDC priorities and addressed in the strategic programme responding to such priorities. Also, some of the non-priority needs coming up through the R&D committees will be identified by more than one committee.

5.10 Coordination of R&D within the new Executive and the wider Department will be improved by regular meetings, chaired by the Department's Deputy Director of Research and Development, bringing together all RDRDs and consultant Directors involved in commissioning NHS R&D, and those responsible for commissioning the Department of Health's own programme of research (see section 10 below). These meetings will *not* be empowered to alter the priorities attached to research needs by the regional R&D committees, the CRDC and the Departmental Research Committee but will consider forward programme plans to ensure they are taken forward in a coordinated manner in order to maximise their usefulness for policy, service and professional interests.

Developing the capacity to undertake R&D needed by the NHS

5.11 RHAs currently provide support to train research workers in areas of health services research where the NHS has the most pressing needs. Responsibility for managing such support will be taken over by regional offices. Meanwhile, RDD is leading work to develop a strategy for NHS and wider departmental support for the development of the capacity to undertake R&D needed by the NHS and Department. This will address the retention and development of research workers and teams as well as their basic training. The research councils, universities and Higher Education Funding Council for England have formal responsibilities for research training and for maintaining and developing the research base. Industry also plays an important role in supporting the research base in the NHS and universities. RDD will discuss needs and possible solutions with all interested parties.

6. ENSURING THAT INFORMATION ABOUT RESEARCH-BASED KNOWLEDGE IS AVAILABLE TO DECISION MAKERS

6.1 An **Information Systems Strategy** (ISS) to support the NHS R&D strategy was approved by the then NHS Management Executive in 1992 following discussion with regions and the CRDC. It provides a framework within which research information systems are developed, managed and used.

6.2 RDD will continue to be responsible for the development and implementation of the ISS and for the management of its three key components: the **project register system;** the **UK Cochrane Centre;** and the **NHS Centre for Reviews and Dissemination.**

6.3 RDRDs and their staff in RHAs have developed a number of initiatives to promote awareness in the NHS of the components of the ISS and supplement their work with local newsletters summarising key research findings and other information. Regional offices will continue to be responsible for promoting an effective interface between the NHS and the components of the ISS. RDD will, at the same time, take the lead in developing a **communications strategy** within the ISS framework to promote effective, efficient and consistent communications between the R&D function in the NHS Executive and the field.

7. PROMOTING THE USE OF INFORMATION ABOUT RESEARCH-BASED KNOWLEDGE

7.1 RDD staff will continue to work with other staff in the Executive Headquarters and the wider Department on the development and implementation of policy to promote the effectiveness of the NHS and, in particular, to promote the use of research-based information by decision makers throughout the service.

7.2 RDRDs and their staff in regional offices will continue the important work with the field that they have been pursuing through the old RHA structures. Working through the regional R&D committees and R&D networks, and in collaboration with public health, continuing professional education and audit, they will encourage and help the field to seek out and use research-based information. They will also work with regional office colleagues in performance management to ensure that health authorities are held to account for their use of research-based information in decisions about service procurement and in contracts for those services.

8. PROMOTING AN EVALUATIVE CULTURE

8.1 DRD and RDD staff in the Executive are responsible for ensuring that Headquarters promotes wherever possible the development of an evaluative culture throughout the NHS in which decision makers seek out and use research-based information and participate in defining NHS research needs and priorities. As part of this, RDD will continue to ensure that decision making processes for R&D in the NHS are open to scrutiny and that information from R&D is freely available to all those in the NHS who need access to it.

8.2 Similarly, RDRDs and their regional office staff will promote the evaluative culture in the regional office itself and, through all the activities described in this paper and other more general advocacy work, the field. The arrangements in regional offices for response-mode research funding described in paragraph 5.5 above are an important way of promoting the evaluative culture in the NHS.

9. DEVELOPING AND EVALUATING THE R&D STRATEGY

9.1 RDD has work in hand on assessing the outcomes and "payback" from R&D to allow evaluation of the contribution which NHS support for R&D is making to the improvement of health through improvements in the effectiveness, efficiency and targeting of NHS services, and to the creation of wealth in the economy. RDD will continue to lead this work, supported by RDRDs and regional office staff.

10. OTHER DEPARTMENT OF HEALTH RESEARCH ACTIVITY

10.1 This paper has outlined the aim, goals and objectives of the NHS R&D strategy and described the functions that will be performed in the NHS Executive and the field to support it. These functions are designed to ensure that the research needs of the NHS field are identified and addressed and that the results of all relevant health research are available to, and used by, the field.

10.2 The NHS Executive is part of the Department of Health. Following the Banks *Review of the Wider Department of Health* (28 July 1994), the Department is to be re-structured into three main areas—health care (including the NHS Executive), social care and public health. The Department of Health's Centrally Commissioned Programme (CCP) of research has been developed over a number of years to meet the research needs of policy makers in the Department. It will continue to work with staff in all three of the Department's business areas to help them identify their research needs and to commission research to meet them.

10.3 The research needs of the NHS Executive—both headquarters and regional offices—will continue to be met through the CCP. There is of course a degree of concordance between research needs identified by Executive staff and those identified by staff in the field. Coordination of the two programmes will be through the mechanism described at paragraph 5.10 above.

NHS Executive

October 1994

Annex A

NHS R&D STRATEGY—AIM, GOALS AND OBJECTIVES

The AIM of the NHS R&D strategy is to secure a knowledge-based health service in which clinical, managerial and policy decisions are based on sound and pertinent information about research findings and scientific developments. This provides the basis for maximising the effectiveness, efficiency and appropriateness of patient services.

The strategy has the following GOALS and OBJECTIVES:

Knowledge: to substantially increase the knowledge base required to evolve and apply effective, efficient and appropriate services. This includes knowledge arising from research and knowledge about scientific and technological advances.

(i) To work with NHS staff to identify and prioritise the R&D requirements of the service.

(ii) To ensure that priority needs for R&D are met by the NHS and other research funding bodies and through international collaboration.

(iii) To ensure that NHS expenditure on R&D is well managed and targeted for maximum benefit.

(iv) To work with others to ensure an adequate supply of skilled staff to undertake the R&D needed by the NHS.

(v) To scan the external environment in order to generate knowledge about scientific and technological developments relevant to the NHS.

Information: to ensure that information about existing research and science-based knowledge is available and accessible for decision-making, and that information about unmet needs for knowledge shapes the R&D agenda.

(vi) To ensure that knowledge from research and the science base is available to NHS decision-makers (policy makers, managers, clinicians and patients) in a way that is appropriate to their needs.

(vii) To ensure that information about research requirements and about ongoing and completed research is available to those planning and managing R&D.

Implementation: to promote the use of research and science-based information by decision makers in the NHS.

(viii) To work with decision-makers in the NHS Executive and the field, and those supporting them, to help them use information about research-based knowledge.

(ix) To develop ways of holding decision-makers to account for their use of information about research-based knowledge.

Culture: to instil into the NHS a culture of evaluation, review and learning, so that information about knowledge is actively sought and applied intelligently in decision-making.

(x) To develop R&D as a part of the regular activity of policy evaluation.

(xi) To work with others to ensure that managers, clinicians, policy formers and service users appreciate how research can facilitate their decisions.

(xii) To develop alliances between the NHS and the research community.

Annex B

KEY FUNCTIONS TO SUPPORT THE R&D STRATEGY

The NHS R&D strategy is based on six key functions that were not in place before the strategy was launched in April 1991:

(i) Identifying NHS requirements for research and science-based knowledge. This involves:
  (a) identifying the problems relevant to policy and practice faced by the NHS Executive and the field;
  (b) determining the way in which R&D can contribute to the solution of these problems, and identifying the key research questions;
  (c) prioritising R&D in terms of the anticipated payback for the NHS.

(ii) Ensuring that knowledge relevant to NHS requirements is forthcoming. This involves:
  (a) making other research funding bodies aware of NHS needs;
  (b) commissioning and managing NHS-funded R&D to tackle immediate problems not being addressed by other funders and supporting R&D of longer-term value to the NHS;
  (c) supporting research in the NHS sponsored by other funders;
  (d) liaising with the Office of Science and Technology and the Department for Education to ensure adequate trained manpower within and outside the NHS to undertake the research needed by the NHS;
  (e) scanning the external environment for scientific and technological developments relevant to the NHS.

(iii) Ensuring that information about research-based knowledge is available to decision makers (policy makers, managers, clinicians and patients). This involves:
  (a) drawing together knowledge relevant to a particular issue in an objective and comprehensible fashion;
  (b) disseminating this information to decision-makers in appropriate formats.

(iv) Promoting the use of R&D findings. This involves:
  (a) working with decision-makers in the Executive and the field, and those supporting them, to assist them in the use of information derived from research and about scientific developments;
  (b) working with others in the NHS Executive to hold decision-makers to account for their use of such information.

(v) Promoting an evaluative culture. This involves:
  (a) developing R&D as a part of the regular activity of policy evaluation;
  (b) working with others to ensure managers, clinicians, policy formers and service users appreciate how research can facilitate their decisions;
  (c) developing alliances between the NHS and the research community.

(vi) Developing and evaluating the R&D strategy.

TABLE 1

Distribution of R&D functions in the NHS

R&D FUNCTION	RDD FUNCTIONS	REGIONAL OFFICE FUNCTIONS	CONSORTIA FUNCTIONS	DHA/FHSA FUNCTIONS	PATIENT CARE PROVIDER FUNCTIONS	RESEARCH COMMUNITY FUNCTIONS
Identifying NHS requirements for R&D	Support CRDC in advising on strategic direction and priorities; support CRDC advisory groups	Support Regional R&D Committees and develop R&D Networks	Regional R&D Committees identify R&D needs and priorities and engage wider R&D Networks	Nominate lead for R&D; work through R&D networks and committees and with RO R&D staff to identify R&D needs and priorities	Nominate lead for R&D; work through R&D networks and committees and with RO R&D staff to identify R&D needs and priorities	Work with R&D networks, committees and advisory groups and with Executive staff to identify NHS R&D needs and priorities
Ensuring that knowledge relevant to NHS requirements is forthcoming (a) Commissioning and managing NHS-funded R&D	Commission and manage R&D centres and units; manage programmes in CRDC priority areas reviewed by advisory groups; ensure coordination of commissioned work throughout Executive and wider Department	Commission and manage projects addressing topics identified by R&D Committees; support local peer review committees and administer local response-mode research grants; promote dialogue between purchasers and providers on innovation and systematic development and evaluation	Promote innovation and systematic development and evaluation by providers and meet service costs of new services being evaluated, as part of consortia commissioning of health services	Promote innovation and systematic development and evaluation by providers; meet service costs of new services being evaluated; join steering groups for R&D projects	Bid for R&D funding; undertake innovation and systematic development and evaluation; join steering groups for R&D projects	Bid for R&D funding; consult purchasers and providers on development of protocols; provide expert advice and peer review to guide commissioning and management of R&D
(b) Supporting other funders' R&D	Promote coordinated arrangements for multi-centre trials	Manage "R" of SIFTR; work with researchers, providers and purchasers to identify service support costs		Work with researchers, providers and regional office staff to identify excess service support costs of projects	Provide access to R&D of value to NHS; work with researchers, purchasers and regional office staff to identify excess service support costs of projects	Work with providers, purchasers, and regional offices to identify excess service support costs

TABLE 1

Distribution of R&D functions in the NHS

(*Continued*)

R&D FUNCTION	RDD FUNCTIONS	REGIONAL OFFICE FUNCTIONS	CONSORTIA FUNCTIONS	DHA/FHSA FUNCTIONS	PATIENT CARE PROVIDER FUNCTIONS	RESEARCH COMMUNITY FUNCTIONS
(c) Developing research capacity	Develop strategy for expansion of capacity for health services research	Manage training schemes		Encourage staff to develop and apply research expertise	Encourage staff to develop and apply research expertise	Encourage staff to develop and apply research expertise
Ensuring that information about research-based knowledge is available to decision makers	Develop, manage and evaluate R&D information systems and communication strategy	Manage Project Register System RO stations; manage information flows to and from field		Use information facilities; communicate needs through R&D Networks	Use information facilities; communicate needs through R&D Networks	Use information facilities; communicate needs through R&D Networks
Promoting the use of information about research-based knowledge	Promote the use of R&D findings in development of NHS policy and strategic framework; develop policies to promote use of R&D findings in the field	Promote use of R&D findings in ROs; through R&D Networks, work with decision makers in the field to help them identify and use R&D findings; hold field to account for use of R&D findings	Seek out and use R&D findings, as part of consortia commissioning of health services	Seek out and use R&D findings; account for use of R&D findings in commissioning of health services	Seek out and use R&D findings; account for use of R&D findings in provider units	Work through R&D Networks and Committees to help decision-makers understand and use research findings
Developing and evaluating the R&D Strategy	Lead work on development of output measures and methods of evaluation	Actively contribute to work on evaluation		Provide views and information on progress	Provide views and information on progress	Provide views and information on progress

Annex C

REGIONAL R&D COMMITTEES

Role

1. The role of the Regional R&D Committee is to:

(i) identify the research needs of the NHS;

(ii) advise, and oversee work, on promoting the uptake of R&D findings in the region.

Terms of Reference

2. To work with the regional office's R&D Network(s) to:

(i) advise the Regional Director of R&D on the research needs of the NHS in the region;

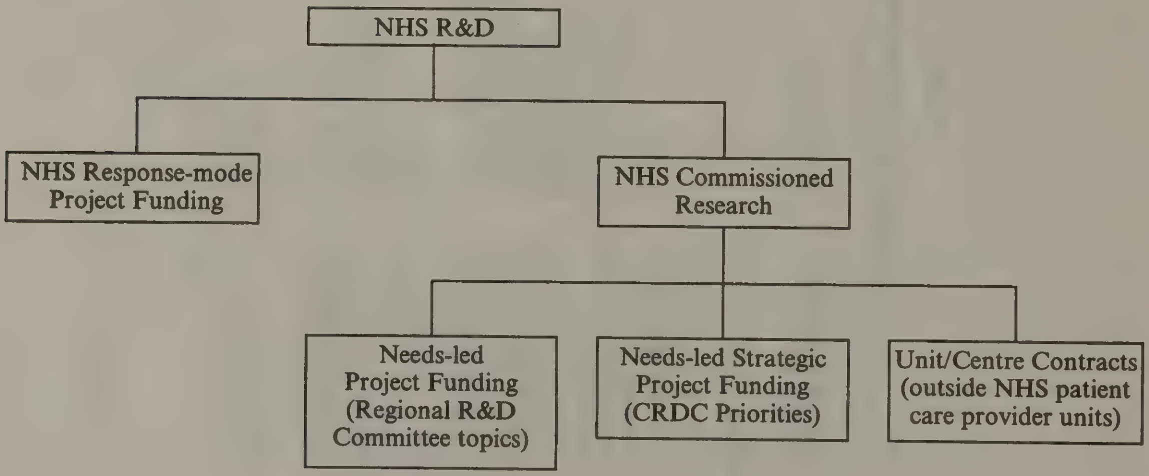
(ii) give advice to the Advisory Groups of the CRDC before they start their work and on their draft reports prior to submission to the CRDC;

(iii) provide advice on the framework within which NHS R&D priorities are reviewed and developed by the CRDC;

(iv) advise the Regional Director of R&D on the most effective means for disseminating and implementing the results of R&D through the regional office's R&D Network(s) and other work with Health Authorities, GP Fundholders, Trusts and with the professions;

(v) consider any other matters concerning R&D which may be referred to it from time to time.

Figure 1


NHS R&D
NHS Response-mode Project Funding
NHS Commissioned Research
Needs-led Project Funding (Regional R&D Committee topics)
Needs-led Strategic Project Funding (CRDC Priorities)
Unit/Centre Contracts (outside NHS patient care provider units)

SUMMARY OF MAIN ACHIEVEMENTS IN NHS R&D PROGRAMME AND RELATED AREAS OF WORK[1]

DEVELOPING AND IMPLEMENTING THE R&D STRATEGY

The post of Director of Research and Development (DRD) was created in 1990.

The first DRD took up post in January 1991.

A Research and Development Branch was established in the NHS Executive in January 1991.

"Research for Health" and "Guidance for Regions" published in September 1991.

The Central Research and Development Committee was established in 1991.

An allocation to RHAs of "tasked" funds was made in 1992-93 to establish regional R&D infrastructures.

All RHAs have appointed Regional Directors of Research and Development and staff to work in Regional R&D Directorates.

All RHAs have appointed Regional R&D Committees.

RDRDs and their staff have formed Regional R&D Networks bringing together key staff from health authorities, trusts, professional groups, the universities and research community, patient groups and industry.

All RHAs published R&D plans in 1992 and 1993; plans for 1994 have appeared or will appear shortly.

The Concordat between the health departments and MRC was renegotiated in January 1992.

A strategic alliance was agreed with the Economic and Social Research Council in 1993.

A Strategy for Research in Nursing, Midwifery and Health Visiting was launched May 1993, following a report from a Taskforce.

"Research for Health" (second edition) published in June 1993.

"Supporting Research and Development in the NHS" was published in September 1994.

"R&D in the New NHS" produced in October 1994 to indicate how R&D will function in the NHS following the Functions and Manpower Review.

A national competition to appoint Regional Directors of R&D to the new regional offices of the NHS Executive was initiated in October 1994.

NHS REQUIREMENTS FOR R&D

A framework and methods were established by the CRDC in 1992 for national and local work to identify NHS priorities for R&D.

Reports have been produced on NHS R&D priorities relating to: mental health; cardiovascular disease and stroke; physical and complex disabilities; the primary/secondary care interface; health technology assessment; cancer; and dentistry. Reports in preparation on nutrition, diabetes, mother and child health, asthma, and effective methods of implementing research findings.

Regions have provided input through R&D Networks, R&D Committees and RDRDs, to CRDC discussions about the framework and methods for identifying NHS priorities for R&D, and to all CRDC reports.

Regions have identified additional needs in areas not covered by CRDC reviews.

KNOWLEDGE RELEVANT TO NHS REQUIREMENTS

Making NHS needs known to other funders

All CRDC reports have been discussed with other research funders. NHS R&D needs have been addressed directly by MRC through the new Concordat. Others have been addressed by the charities.

NHS direct support for R&D

Centrally funded NHS programmes of R&D have been established in: mental health; cardiovascular disease and stroke; physical and complex disabilities; primary/secondary care interface; health technology assessment; and cancer.

RHAs have funded work in other areas where the NHS has identified needs for research-based information.

---

[1] This list covers achievements most relevant to the enquiry of the House of Lords' Select Committee on Science and Technology into Medical Research and the NHS Reforms. The DH R&D Strategy also covers policy related research commissioned through the Department's Centrally Commissioned Programme, and alliances with the scientific community, other funders of research, other government departments and the European Union. Many of the key achievements in these other areas are not listed here.

Contracts for R&D were awarded to SHAs and ex-SHA Trusts in September 1994 following an independent review in 1993 of the London Postgraduate Special Health Authorities.

A new MEDILINK programme has been established with the aim of improving technology transfer, industrial competitiveness and the quality and efficiency of NHS patient care through the improved application of physical and engineering sciences to medical diagnoses, treatment and rehabilitation.

The Research and Development Directorate has coordinated and led the development procedures in the Department and RHAs for commissioning and managing R&D.

A Project Register System has been developed, bringing together regularly updated information on research funded, or about to be funded, by the Department, RHAs and the MRC, and making this information available to all these bodies. Work is in hand to extend coverage to other funders of health research and to make the information on the system more widely available to those planning, developing and managing research projects.

Support for other funders' research in the NHS

RHAs have improved the contractual arrangements for the research element of SIFTR.

Discussions between MRC, the Department of Health, RDRDs, Trust, health authorities and research workers have ensured the success of a number of key studies under the existing arrangements for service support.

The NHS Research Task Force (Culyer) report has set out the basis for improved arrangements for service support.

Developing research capacity

The Review of Department of Health Funded Research Units (the Williams report) produced in 1992 recommended concentration of the Department's support long-term support for health services and personal social services research on a smaller number of larger research centres.

A contract was awarded by the Department to the University of Manchester in 1994 for a Primary Care Research Centre, a major new centre along the lines proposed in the Williams report.

In 1994 the MRC approved a bid from Bristol in association with other universities for a new Health Services Research Initiative. The initiative, which focuses on research into methodological development and research training, will complement the NHS R&D programme.

Agreement has been reached on the foundation of a Jenner Institute for Vaccine Research as a partnership between the Department of Health, the Biotechnology and Biological Sciences Research Council, the Medical Research Council and industry. Amongst other things, this Institute will increase capacity for applied research of direct value to the NHS and public health.

RHAs have provided funds for a number of training initiatives in health services research, some run jointly with MRC.

MOBILISING RESEARCH-BASED INFORMATION

An R&D Information Systems Strategy was approved by the (then) NHS Management Executive in 1992 following an analysis of NHS needs for information about research and research findings.

The UK Cochrane Centre (Oxford) opened at the end of 1992 and was reviewed. A pilot module was produced and released in 1993 of systematic reviews of research in pregnancy and childbirth. Systematic reviews in other fields will be released in prototype in December 1994.

The NHS Centre for Reviews and Dissemination (York) opened in December 1993. The Centre has completed three reviews and has work in progress on a further nine. Work on a database of reviews, to be available on-line to enquirers, is well advanced.

Seven Effective Health Care Bulletins and 20 Epidemiologically-based Needs Assessments have been published and distributed to the NHS between 1992 and 1994.

A pilot cost-effectiveness register was distributed to the NHS in 1994.

RHAs have commissioned other reviews on areas of concern to decision makers in their region. These are being entered onto CRD databases.

RHAs have also developed newsletters and other initiatives to improve the interface between users and the UK Cochrane Centre and the Centre for Reviews and Dissemination, and to communicate the findings of research and reviews of research to decision makers in their region.

A report on R&D aspects of genetics was produced in 1994 to guide future NHS R&D in this area and form the basis of advice to the NHS about the implications of basic research in genetics; this provides a model for further work on scientific foresight for the NHS.

USE OF RESEARCH-BASED INFORMATION

Executive letters (ELs) were issued in 1993 and 1994 to the NHS promoting the use of research-based clinical guidelines and a range of information sources on research findings. The Department is working with the professions to promote the production of further high quality, research-based guidelines, and with purchasers and providers on the development of research-based service specifications.

RDRDs are working through the Regional R&D Committees and Networks to promote similar work at a local level and to help purchasers understand and use research findings. There are now a number of local development projects in this area, including the Oxford GRiP initiative (Getting Research into Practice).

The NHS Centre for Reviews and Dissemination (York) opened in December 1993.

PROMOTING A SCIENTIFIC CULTURE

The R&D strategy has been widely promulgated by Departmental (including NHS Executive) and regional publications, speeches and conference presentations, articles in the national press and papers in specialist journals.

A number of major policy initiatives have emphasised the importance of R&D (eg "Health of the Nation", "Making London Better", "Realising our Potential").

The 1993 and 1994 ELs described above emphasise the importance of seeking and using research information and instruct purchasers and providers not to purchase or supply new forms of health care currently undergoing evaluation outside those evaluations.

The latest guidance to the NHS on priorities and planning for 1995-96 makes it a medium term priority that purchasers and providers should invest an increasing proportion of resources in interventions which are known to be effective and where outcomes can be systematically monitored, and reduce investment in interventions shown to be less effective.

The presence and contribution of the Director of Research and Development at meetings of NHS Executive has placed R&D firmly on the top level agenda. His membership of the Clinical Outcomes Group ensures the link between R&D and work on audit and outcomes.

The presence of RDRDs in RHAs has also helped to ensure R&D is addressed at this level. Support for R&D from the Executive Board has played an important role in supporting this work by RDRDs.

RDRDs have undertaken a range of local work to promote the scientific culture more widely in the NHS. Much of this is done through the R&D Networks and informal networking in the regions. RDRDs and others associated with the programme are held in high regard by their respective professional groups and this has provided another important route for promoting the evaluative culture. Other work has included liaison with education, training and management development in regions, and research funding arrangements which encourage wider NHS participation in research.

R&D IN THE DEPARTMENT OF HEALTH

INTRODUCTION

1. In July 1994 the reports of two wide-ranging reviews were published. "Managing the New NHS" sets a framework for the future organisation of the NHS. The Banks report, "The Review of the Wider Department of Health" considers the future management structure of the Department. These reviews are now being implemented.

2. Following the recommendations of the Banks report, DH will work as one Department with three main business areas: health care, social care, and public health. Each business area will be responsible for a full cycle of policy development, implementation, monitoring and review, and for reactive casework and executive functions. Within this framework the NHS Executive will function as an integral part of the Department, developing and implementing the Government's policies for the NHS, holding health authorities to account and advising Ministers.

INTEGRATING POLICY AND IMPLEMENTATION

3. One aim of reorganising the Department is to bring policy making and operational management closer together, promoting better integration between policy and implementation. Closer links between operational management and policy making are intended to provide a better knowledge of what is happening on the ground, provide more opportunities for operational input and promote a wider ownership of policies once developed.

4. The Banks report recognizes, however, that much of the work undertaken by DH is inter-connected and crosses organisational boundaries, eg work on services for people who are mentally ill. Promoting greater coherence across the whole range of DH policy and implementation will, therefore, involve more proactive management of the Department's work as a whole, with clear lead responsibilities, better arrangements for

collaboration and mechanisms to ensure that important issues are not overlooked. There will also be a mechanism to identify major issues likely to impact on health and social care in advance.

5. Within these arrangements the Banks report recognised that the role of the Research & Development Division is to ensure that the three main businesses give adequate emphasis to research and to help them define research programmes and commissions that further their client and service objectives. Annex 1 explores how the Division will fulfil this role in relation to the development, implementation and evaluation of policy, helping to promote coherence and consistency across the three businesses and the collaborative activities. Annex 2 (*printed above*) describes the role of R&D in the new NHS.

The Research and Development Division

6. The work of the Division encompasses NHS R&D and centrally commissioned research within the context of the DH R&D strategy, which also includes the health research of the non-departmental public bodies, and relations with the Office of Public Service and Science, with other Government departments, with the MRC and other research councils, with charities, industry and the European Union.

The DH centrally commissioned programme

7. The CCP maintains the impact of R & D on policy and operational strategy across the three Departmental businesses. Significant proportions of the CCP budget are allocated to work on social services and on public health issues, such as nutrition and environmental problems. The CCP also addresses major issues of NHS policy, pan-service issues and matters on which there is a central strategic remit.

The NHS R & D Programme

8. The NHS R&D Programme on the other hand is responsive to operational requirements and supports the R&D needs of NHS purchasers and providers and those who use the service. It concentrates on issues of direct concern to managers and clinicians working in the service. This work supports operational decisions, the development of local purchasing strategies and the provision of services. Much of the output is information on the effectiveness and cost-effectiveness of different forms of intervention and different models of care.

Co-ordination

9. The NHS R&D Programme and the DH Centrally Commissioned Programme address different needs and have complementary objectives. To ensure good coordination between these programmes RDD functions as an integrated division with flexible working practices which maximise the use of staff across the Division. The two programmes are planned and coordinated within the context of the DH Strategy to provide coherent R & D input to policy and operational management across the whole range of the Department's business and the functioning of the NHS.

10. Following the Banks recommendations, the CCP will continue to meet the research needs of the NHS Executive. Coordination will be maintained by consistent working practices in each programme, regular staff interaction and effective IT support using the new R & D Project Register System. More formally, coordination will be strengthened by regular meetings between those concerned with commissioning in both programmes.

11. RDD interfaces not only with policy and service colleagues across the Department and the NHS but also with the research community in universities, medical schools and the NHS. Many of these connections are contractual relationships where RDD is commissioning high quality research on behalf of DH and the NHS. The Division ensures that these contractual relationships are dealt with consistently and fairly, and that they are in line with Government policies and acknowledged good practice in research management. The use of peer review, rules about competive tendering, IPR and indemnity, are all sensitive issues on which it is important that RDD sets high and consistent standards in its dealings with the research community on behalf of Ministers.

Structure

12. The Banks report notes that present arrangements for RDD within the Department work well, and recommends that they should continue.[1] RDD will continue to work as an integrated Division, building on existing working relations with colleagues in the three Departmental businesses to identify and address R & D needs, and supporting new arrangements for business planning across the Department.

ANNEX 1

R&D IN POLICY MAKING AND OPERATIONAL STRATEGY

Introduction

1. Following the Banks report there will be changes in the way the Department's work is planned and managed. It will be the role of the Departmental Management Board, supported by the Policy Management Unit, to ensure that policy development and review is planned and prioritised. Policy development and review will be planned to:

- include evaluation of options, implementation costs and information requirements;
- include time limits for developments, implementation, monitoring and evaluation phases;
- allocate clear responsibility for implementation, including decisions on the "levers" to be used;
- develop monitoring methods and evaluation criteria.

The research/policy cycle

2. These new arrangements highlight the different stages in the policy cycle, and make it clearer where contributions from research and development can be made as policy is developed and implemented. Appendix 1 illustrates the research/policy cycle and shows the complementary roles of policy makers and RDD. Details of the interactions at each stage are given below.

3. Ensuring an effective R&D contribution to policy and operational strategy requires continuity between the generation of research knowledge and its practical application. The functions of RDD therefore cover:

(a) maintaining a good understanding of, and interaction with, the science base—so that emerging findings in basic science and applied work supported by other funders can be identified and exploited by DH;

(b) brokering well developed relations between researchers and policy makers, enabling the former to address policy makers' needs more effectively and the latter to use the results of research wisely. This ensures that policy makers have a well-informed voice in setting the research agenda, and that work is commissioned in the light of existing knowledge and of possible research solutions;

(c) helping colleagues to set feasible research priorities;

(d) commissioning high quality, well targeted research on issues of priority importance to Ministers and colleagues across the Department in support of Ministerial aims, goals and objectives;

(e) enabling, and working with, policy colleagues, through their involvement in these processes, to use the results of research effectively to support their work, and ensure dissemination of robust findings.

Details of the specific tasks involved are given in Appendix 2.

Interaction with the science base

4. Many new developments in basic science and applied research have important implications for health and social care. But if policy makers do not become aware of these developments opportunities for improvement will be lost and it will be difficult to respond appropriately to pressures for new, unevaluated services. Through a number of formal and informal interactions with the scientific community RDD contributes to the DH pool of information about the scientific context of health and social services.

5. RDD has a growing ability to provide research briefing on work funded by the Department, the NHS, the MRC and (to a lesser extent) other funders in the development of the R&D information strategy. A major new enhancement to this is the development of the London data-base documenting CCP projects and the ability to interface the NHS Project Register System.

6. There is increasing demand from colleagues in DH and the NHS for good intelligence about the science base. The Technology Foresight exercise developed by OPSS is providing a systematic approach to forward planning across government, and DH is aware of the need to have policies in hand in readiness to deal with scientific advances as they emerge.

---

[1] "Review of the Wider Department of Health", p. 31.

7. Through its interaction with the scientific community RDD has an important role in this. RDD supports scanning exercises which aim to ensure that emerging problems are tackled early and that important scientific opportunities are appropriately exploited. Current work in genetics, for example, will have implications for all the three Departmental businesses and for effective business planning across the Department.

8. The number and range of other governmental and non-governmental bodies sponsoring research is very large. RDD interfaces with these bodies on research issues on behalf of Ministers and colleagues across the Department. A major objective is to ensure that the DH R&D Strategy is known about and taken into account by these other bodies. DH leads the field in laying out its policy and service R&D priorities so that other funders are encouraged to meet the needs of DH and the NHS. Concordats with all the major research councils ensure that the DH voice, focused through RDD, is heard consistently and coherently. Relationships with other government departments, OST, the European Union, and HEFCE that are managed through RDD ensure that the research interests of these bodies take DH needs into account.

Research and the development of policy

9. The huge range of Departmental business, the pace of policy and operational changes, resource constraints, and limitations in available research and research management expertise make it difficult for RDD to maintain the impact of R&D on all aspects of DH policy. Priorities have to be set which reflect the major strategic concerns of Ministers and divisions on Ministers' behalf.

10. R&D input is provided at a number of stages (see Appendix 1). Existing research can be used to help policy makers to identify a particular problem more exactly, placing it in the context of the latest evidence from research and management information. RDD is committed to increasing the number of research reviews it carries out in support of policy activity (Stage A). This enables policy options and approaches to be developed that are robustly founded on a good knowledge base (Stage B). Policy action can then be taken, long term research gaps noted and, where appropriate, new research commissioned (Stage C).

RESEARCH AND THE IMPLEMENTATION, MONITORING AND EVALUATION OF POLICY

11. As new policies are put into operation, research studies are established to contribute to a multi-faceted evaluation of their operation and outcome (Stage D). When the results of evaluation indicate that fine tuning is needed, ameliorative action can be taken. When the results of evaluation suggest that there is pressure for a further policy initiative, these can be given careful consideration (Stage E). The cycle may then start again, aided by any further research that has become available in the interim.

12. Following Banks, the new emphasis on the planned incorporation of monitoring and evaluation into policy development and review will provide clearer opportunities for RDD to discuss R&D input with policy makers and other colleagues such as EOR and SD and HMU.

Promoting greater coherence and consistency across DH policies

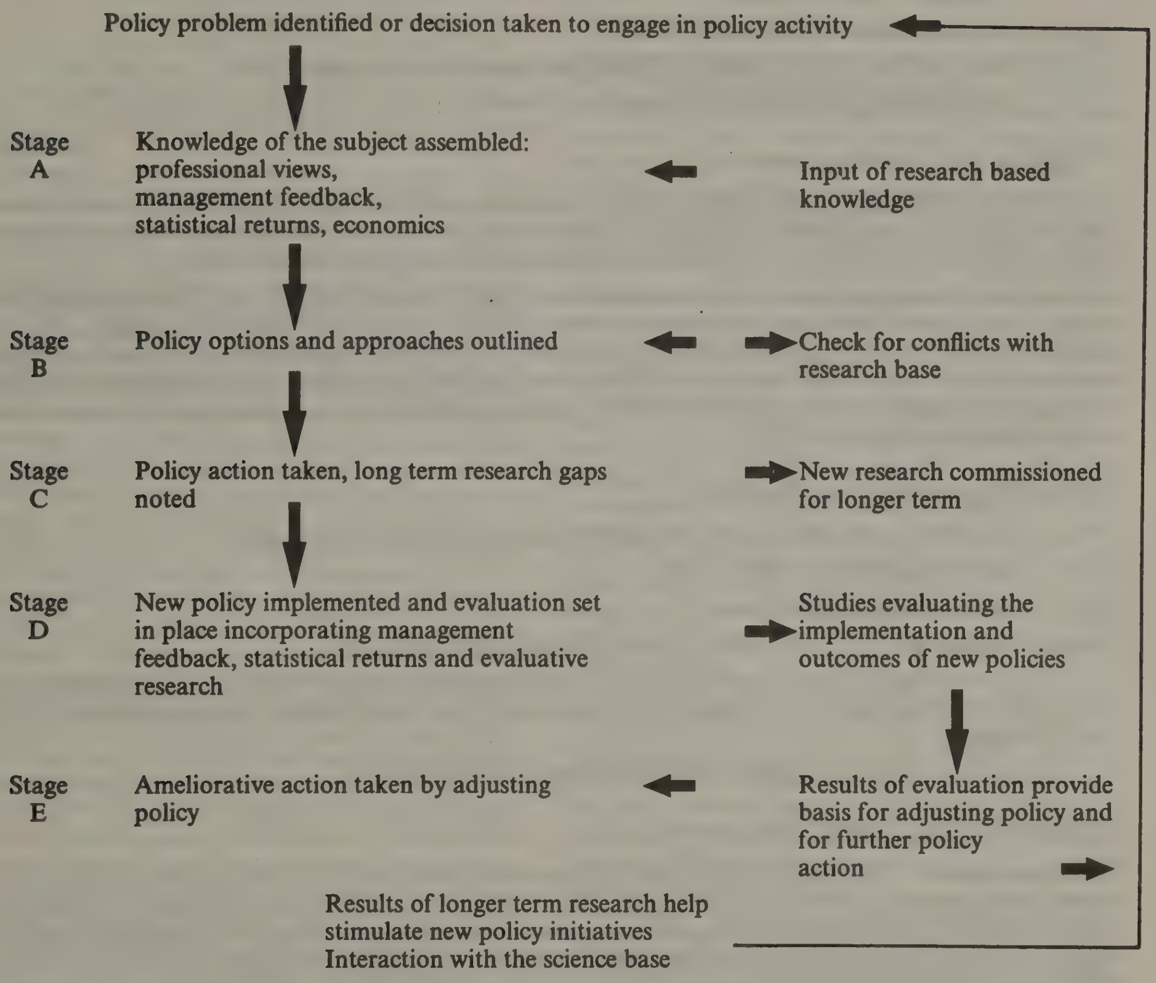
13. Banks makes it clear that the new arrangements proposed in the report will pose a significant challenge for the Department. Ensuring the work of the Department is consistent, coherent and manageable will be the role of the DMB, supported by the Policy Management Unit. RDD, because of its special position in relation to the three business areas, is well placed to support work which straddles boundaries and addresses overarching issues. The balance of research effort can be adjusted as the balance of priority activity shifts between businesses. In response to important scientific developments, RDD will be able to work with policy makers on a coherent set of policies that cover Departmental interests.

14. Similarly, when working with policy makers in one area, RDD may commission research that is also relevant to other areas of the Department's work. It is already an important part of RDD's role to ensure that the progress and results of commissioned research are made widely available to all those who need to use them. Maintaining these sort of contacts between the work of the different areas will be an important contribution to the overall coherence of DH activity.

15. To ensure that the impact of R&D is maintained across the whole range of the Department's work and that the R&D needs of each area are appropriately addressed, RDD will continue to work as an integrated Division which has close working relations with each area and provides support to business planning across the Department as a whole.

APPENDIX 1

THE RESEARCH/POLICY CYCLE


Policy problem identified or decision taken to engage in policy activity
Stage A
Knowledge of the subject assembled: professional views, management feedback, statistical returns, economics
Input of research based knowledge
Stage B
Policy options and approaches outlined
Check for conflicts with research base
Stage C
Policy action taken, long term research gaps noted
New research commissioned for longer term
Stage D
New policy implemented and evaluation set in place incorporating management feedback, statistical returns and evaluative research
Studies evaluating the implementation and outcomes of new policies
Stage E
Ameliorative action taken by adjusting policy
Results of evaluation provide basis for adjusting policy and for further policy action
Results of longer term research help stimulate new policy initiatives
Interaction with the science base

APPENDIX 2

FUNCTIONS INVOLVED IN DEVELOPING & MANAGING A RESEARCH PROGRAMME FOCUSED ON POLICY NEEDS

(i) *Interaction with the science base*

RDD has formal relations with the research councils and a large number of informal relations with individuals in the research community to ensure that:

- RDD can provide good intelligence about emerging findings in basic science
- DH policies and NHS priorities are known to other funders of research

(ii) *Creating the informed customer*

In order to use the research budget effectively RDD works closely with DH colleagues to ensure they are informed about:-

- the process of calling on the budget
- what research can and cannot deliver on particular timescales and pitfalls
- research knowledge already available
- expertise likely to be forthcoming

(iii) *Prioritizing issues, constructing a research brief, commissioning work*

The CCP has clear criteria for prioritizing work via the Departmental Research Committee. These include ministerial priority, likely impact on policy, and potential 'payback'. RDD engages with colleagues in:

- setting priorities for research
- the formulation of the research brief
- decisions about how to secure proposals and ensuring quality control
- commissioning, contracting and financing the work

(iv) *Management of ongoing research*

Iteration with colleagues ensures that research can respond to developments in policy as they progress, and that colleagues are kept in touch with results as they emerge. It is RDD's job to ensure that this contact is maintained, that projects report to time and on budget and that problems are dealt with.

Oversight of the programme as a whole ensures that a balance is maintained not only between subject areas but, for example, between long medium and short term R&D. Currently RDD has 230 contracts. Some of these are fast response projects, some fund programmes which address strategic initiatives, and in addition there are 13 with long term research units. RDD constantly reviews this balance seeking improvements which will ensure high quality value for money research on issues of DH priority. An example of this is the cautious move to funding research centres.

(v) *Reporting and utilization of research*

The rationale for a research project is its use in policy activity. RDD ensures that:

- project reports cover policy issues
- reports meet the initial aims
- research output is scientifically robust, by peer reviewing reports
- a dissemination plan is drawn up so that researchers disseminate results via the academic and professional press, by seminars, conferences etc. These often involve divisional input and RDD support
- appropriate action is taken by DH to inform the policy process

(vi) *Contractual and Financial Management*

The management of the programme is governed by a set of principles and procedures which ensure value for the resources committed to research and compliance with certain unavoidable requirements. Each project has to satisfy peer review and be agreed by relevant policy and professional colleagues; EC regulations require tendering across Europe; all commissioned work must accord with the Departmental Code of Research Practice introduced in 1993. The budgetary planning and control procedures are kept as simple as possible concomitant with the number of contracts let, the necessity to refine costs during the planning period and unforeseen problems eg of scientific design which can impact on costs in the course of the work. Contracts are issued on an approved cost basis and with standard conditions.

Examination of witnesses

PROFESSOR MICHAEL J PECKHAM, Director of R&D, and PROFESSOR GILBERT SMITH, Deputy Director of R&D, Department of Health, were called in and examined.

Chairman

1. Thank you very much for coming to talk to us. If it would be appropriate perhaps you would care to make an opening statement before we get on to the questions?

(*Professor Peckham*) Thank you very much indeed. Could I start by introducing Gilbert Smith who is Deputy Director of R&D who joined me in 1993. Can I say that we very much welcome the chance to give evidence so early in your deliberations. It comes at a particularly important time following the publication of the NHS research task force, or Culyer Report, but also following the Functions and Manpower Review of the NHS. I would just perhaps say in passing that we see opportunities that can be taken from both: the functions and manpower review for a strengthened regional and central structure for R&D and also in the Culyer Report which I have no doubt you will come on to discuss. We have submitted to the Committee the main events of the NHS R&D programme since the launch in 1991. I just would like to make one or two comments. Following the House of Lords' Select Committee Report "Priorities in Medical Research" we have given emphasis to health services research and related areas of applied research because there was perceived to be a gap in that area. We have given a lot of emphasis to the mobilisation and use of existing research findings which was an area of neglect. We have put emphasis into relating the health service to science and technology and to the science base, since we felt that was important and needed strengthening. I make this point because I have seen strengthening clinical research as being a very important endeavour as well as strengthening health services research and there is no conflict in my mind between the two, we have to see that we are strengthening both areas, they are both necessary. The United Kingdom has been very strong in clinical research but I think it is really quite salutary to look at some inherited weaknesses that go back a considerable time. For example, in the past only a small percentage of patients have been entered into randomised controlled clinical trials, this is certainly true of the cancer field and no doubt other fields. In some cases the research training of doctors has left much to be desired. There has been little health services research and I think this has been a substantial disadvantage to the NHS. There has also been little research in primary care and that needs to be corrected. If we look at the Science Watch Report on United Kingdom clinical research between 1980 and 1990 we see that the number of published papers increased while the number of citations dropped and the proportion of un-cited papers increased. It was concluded that there was a considerable output from clinical research but much of it was of marginal value. We might question that but there is perhaps something to be taken seriously in that area. Just to briefly comment on Culyer. We have had a positive response to the recommendations generally from the scientific press. We have had discussions with the MRC that have been very encouraging and they continue. We have had a very positive response from the Association of the British Pharmaceutical Industry and we now have plans to meet all the other collaborating parties over the next month or so. The Secretary of State has indicated her intention to make available more funds to protect teaching hospitals' research in 1995-96 and we anticipate an announcement about this quite soon. The Secretary of State has also indicated that she will look sympathetically at directing more NHS funds in 1996-97 to build up the research funding stream recommended by Culyer. Just a final point: I do see the task force recommendations as a challenge not just for us, the Research and Development Division centrally, but a challenge for us working with the research community and the research funders. I think there is a huge opportunity but I do not underestimate the complexity of the task. To make the recommendations work we will certainly need a co-ordinated effort and that is certainly the spirit of our discussions. For example, the identification of what we might call hidden or implicit research funds will be important if they are to be protected and ring-fenced and that will require an effort, not just on our part but from the NHS and academic community more generally.

2. Thank you very much. When the Select Committee of this House made recommendations that there should be a Director of R&D, namely yourself, and a number of other recommendations, they discovered the amount of NHS expenditure on research was 0.1 per cent and Government agreed to move gradually towards 1.5 per cent. What was the thinking behind that figure?

(*Professor Peckham*) I think when the programme started in 1991 it seemed to me very important to establish the principle of a percentage commitment of funds to R&D and that we would not, on a year by year basis, have to negotiate a sum. So we saw that as being absolutely crucial. How to fix a percentage, well it was difficult because there was no detailed knowledge of the amount of NHS funding spent on research and indeed that remains the case in part. We estimated that if one took the service support funds into account together with other expenditures that about 0.9 per cent of the NHS budget could broadly be said to be spent on research and the support of research. We saw that it needed to increase to cover the areas that we saw as important and we then made, if you like, an empirical decision based on the usual R&D expenditure of service industries which is between one and two per cent and set the target figure of 1.5 per cent. I think that has been a very useful target which we have worked towards but as the recommendations of the Culyer report are implemented we will no longer need to be enslaved by it.

3. May I take it then that until Culyer the Department did not separately identify the infrastructure funding for service support required, for instance, to underpin the curiosity-driven clinical research in the health service? No such identified figure was available, is that a fair comment?

(*Professor Peckham*) That is correct, yes.

[Chairman *contd.*]

4. That is one of the tasks that lies ahead?

(*Professor Peckham*) That is one of the tasks that lies ahead, to identify hidden or implicit research funding.

5. Could we then ask whether you would be kind enough just to explain the items and exclusions in table two in your memorandum which was DH/NHS R&D expenditure 1994-95?

(*Professor Peckham*) Yes. This table two actually appears in the Forward Look of Government Funded Science, Engineering and Technology published this year. The figures that are set out are DH/NHS R&D expenditure, £62 million, SIFTR £120m, the London Postgraduate Hospitals £253m and the non SIFTR scheme £2 million. The DH/NHS amount of funding includes the centrally commissioned programme of the Department of Health plus some other research funded by the Department outside that centrally commissioned programme. It also includes the NHS centrally funded programme of work on national priorities identified by the Central Research and Development Committee and the research of non Departmental public bodies. What it excludes is regional expenditure by the Regional Directors of R&D on NHS research. I can now add to that, and tell the Committee, that in fact the current expenditure on regional R&D through the Regional Directors is approximately £35 million. What is excluded also is the point that you raised, Chairman, which is the trust or provider units' own expenditure on research and the service support of research, the hidden commitment to research that has not yet been quantified. This component also includes any expenditure on research by health authorities including family health service authorities and GP fundholders. We have no knowledge of what that might be.

6. Are you aware of any continuing expenditure at a local level from the trust funds that were based upon the original endowments of the voluntary hospitals before the NHS came in, which in many cases were quite substantial?

(*Professor Peckham*) Yes, we are aware of continuing expenditure but, of course, we do not have details of it.

7. You do not have a figure?

(*Professor Peckham*) We do not have a figure and we do not have information about the nature or indeed the quality of it.

8. The two million for non-SIFTR expenditure, supporting research in hospitals which are neither special health authorities nor do any undergraduate teaching. Are they eligible for SIFTR? When you define hospitals doing undergraduate teaching do you take account of the fact that now an increasing number of regional hospitals throughout the country do take medical students from the various medical schools? In assessing that figure does that take account only of those hospitals which are major undergraduate teaching hospitals?

(*Professor Peckham*) The recognition of undergraduate teaching by hospitals that work with teaching hospitals is taken account of in the sub-regional allocation of SIFTR funds. The two million pounds, which is somewhat curiously known as non SIFTR, refers to the allocation of service support to non-teaching hospitals which have an important research function and there are criteria for that. It must be more than £100,000 research grant income per year; or it must amount to one per cent of the hospital budget. There are five hospitals which actually qualify for that, for example Harefield is one. That is based on research grant income.

Earl of Selborne

9. Given that it is necessary to identify these diverse existing sources of funding, some of which could be from endowments as you suggested, Chairman, and some could be raised from local voluntary, some from NHS health care resources, to what extent would Professor Peckham think it is feasible that all these diverse sources of existing research funding could be put into one single explicit funding stream?

(*Professor Peckham*) Well, I think that it is an attempt that needs to be made, although I do not under-estimate the difficulty of doing it. I am concerned to see that the amount of money being spent on research conducted in hospital trusts, in teaching trusts particularly is identified and ring-fenced, and captured in a single research funding stream and not lost to patient care. Currently, this is not quantified. It includes the direct and indirect support of research and the service consequences of research. The amount requires to be identified and we are proposing to develop costing methods to achieve this. I think that we have to accept that this may need to be a broad brush approach but we should definitely make the attempt to do it.

Chairman

10. We have already referred in passing to the so-called curiosity-driven clinical research but there is a problem which is apparently growing about disincentives against extra-contractual referrals. Perhaps I could refer, just by way of example, to one piece of evidence we have received from Professor R.A.C. Hughes at the Guy's and St Thomas's Medical and Dental School. He has carried out for many years research into a pretty rare condition, the Guillain-Barré syndrome, and has been involved in multi-centre trials of treatment. In the past a considerable number of patients have been referred from across the South East of England to his unit for inclusion in these trials.

(*Professor Peckham*) Yes.

11. Now he is pointing out that many consultants are now inhibited from sending patients to his unit because the local health authorities are unwilling to bear the costs of these referrals. He points out, for example, that in 1990 and 1991 26 such patients in each of those years were referred to his unit, 19 in 1992, 16 in 1993 and in the first ten months of 1994 four patients. This is something which is being brought to our attention from other quarters. I wonder what views you would have about how this problem can be overcome.

(*Professor Peckham*) I certainly recognise the problem that you have raised. As the Culyer Report points out it may be difficult to distinguish between

[Chairman *contd.*]

an extra contractual referral that is a referral primarily made on the basis of research from a referral that is clinical and where research may be an adjunct. We will look at the feasibility of a case for extra contractual referral support for research purposes and if a strong case can be made consider how this might be funded. I do believe that there is actually a broader issue here which is about reconciling the conduct of research with the future organisation of health services. I think this is not a problem that is confined to this country, it is a problem that many other countries are experiencing. There are some intrinsic or inherent shifts in the organisation of services, for example the increasing emphasis on primary care, the more rapid transit of patients through hospitals and rethinking about outpatients and ambulatory care and so on. I think that if we recognise that then there is a challenge, again not just for us but for the centre working with the academic community and research funders, to consider how the organisation of research could adapt creatively to changing health care patterns. One important development I think is the dialogue or coming together of purchasers, providers and academics in an interactive way to discuss how service configurations and research strength can be reconciled. I think this is crucial and such discussions are certainly taking place in London and elsewhere. I could say in parenthesis that the Regional Directors of R&D together with their emerging networks are going to be very important in this context. In summary, yes, we will of course look at ECRs and do what we can to correct current anomalies but I think there is a broader issue that we all need to actually tackle.

Baroness Jay of Paddington

12. I wonder, Professor Peckham, if you could comment on two structural organisational things that arise directly from the general point you are making. One is the need for different guidance on tertiary referrals and, secondly, the ongoing question and debate about the future of SHAs and how, particularly in London, they will be affected by the financial outcome of Culyer if it is adopted as it stands?

(*Professor Peckham*) Yes. The issue of tertiary referrals—I think some of the points I have raised are also true for tertiary referrals, particularly perhaps the tertiary referral of patients with common conditions that would perhaps not be referred other than for research purposes. I think that we recognise the problem and we will think through potential solutions to that. I think it is again a question to trying to look to the future and see how, for example, trials may be conducted that do not require necessarily the concentration of patients with common diseases. I am not proposing a definite solution to that now. As far as the former SHAs are concerned, as you know the funding arrangements for them are designed to sustain their research and development following the review chaired by Sir Michael Thompson last year and it is envisaged that they will enter into the patient care market. Six of them have become trusts from April this year and the other two are likely to in due course. We envisaged, following the Thompson review, that the R&D funding arrangements would be provisional until there was a national scheme for allocating service support funds in relation to the assessment of quality and importance of R&D. This now is precisely what Culyer points us in the direction of. We will be working with the former SHAs to integrate them into the scheme that emerges from Culyer.

13. Would it be sensible though, given the acceptance by the Department of the main recommendations of Culyer about ring-fencing the single stream of research funding, if the SHAs were, as it were, withdrawn from the internal market?

(*Professor Peckham*) I think that my comment would be that there is an argument for them participating in the same way as other hospitals and not remaining as anomalies funded in a different way. I do not think this would be in their long-term interests.

Chairman

14. I believe that everyone is very happy in general terms about the way in which your R&D initiatives and the way in which they have developed over the last few years have been able to support health services research. We think that this has been a major development of great importance. I think there are concerns that if, as Culyer proposes, purchasers and providers agree between them on how to support the curiosity-driven clinical research there is a serious anxiety that such activity might be squeezed out altogether. I am sure this is not your wish. I wonder how you see it being protected.

(*Professor Peckham*) Just a general comment about undirected pre-protocol or curiosity driven research. I think it is essential that we do distinguish between really useful high quality research and poor quality research that simply is not associated with a protocol and which has not been won on a competitive basis and so on. However, it is often argued by the clinical scientists' community, particularly physicists and biochemists, that pre-protocol research is something that is very important to them, for example in developing a new prototype and that this constitutes research that may not be associated with a written protocol. In this sense it is implicit research. Similarly, in clinical research if you appoint quite high calibre staff it is likely that they will become involved with research which will eventually lead to grant application and a formal protocol. That is by way of a general comment. I think we need to understand much better what is involved in pre-protocol or curiosity driven research in the context of hospitals or indeed primary care, and then to get some measure of its importance. I do not doubt its importance but I think that we need actually to be a little bit more definite about defining it. I should add that many aspects of the Culyer recommendations are currently under discussion with research funding bodies and other partners and that an announcement will be made by the end of the year about the implementation plans. If I can just comment in a provisional way about this. One possibility for supporting pre-protocol or curiosity driven research in the NHS context would be to make provision for it as part of the research facilities

[Chairman *contd.*]

contract. This type of work will predominantly happen in academic settings where there is high quality protocol associated research. The other possibility would be to identify a specific reserve. We will be looking at both these possibilities. We recognise the importance of the issue. I would like to clarify the issues in discussions with the academic community and research funders.

15. Thank you. Culyer seems to propose assessment of the quality of research being undertaken in specific hospitals, perhaps major teaching centres, something comparable to the kind of research assessment exercise which is undertaken by the higher education funding councils with the implication that as time goes by the research fund allocation for support of such research in the hospital service will be monitored from the centre and to some extent changed by the centre based upon such an assessment. Now on the one hand that seems to be a very sensible arrangement and yet on the other what is not clear is how much of these budgets will be devolved to regional or local level. Have you any ideas as yet as to how the top down allocations will be looked at in comparison with funds which are devolved regionally or locally?

(*Professor Peckham*) I just comment about the first aspect of your question about research assessment. We feel we were pioneers, or Sir Michael Thompson was a pioneer in this, having conducted the first review of NHS institutions as opposed to medical schools in London postgraduate hospitals. That review was labour intensive and involved a great deal of academic time but I think it was very important because it established the principle and a method of looking at NHS hospitals' R&D, not just from the point of quality but to gain some idea of the importance of the work being carried out in the hospital context to the NHS. I think it is fair to say that that has had not only a practical outcome in determining the allocation of NHS funds but a very stimulating and catalytic effect on the postgraduate hospitals. I think we see this in several of them, perhaps one might single out as an example the Maudsley Hospital where the NHS support, I think, has been quite instrumental in attracting MRC support for the new centre headed up by Sir Michael Rutter. We intended at the outset at that time to extend the Thompson review nationally but it would be sensible, not only sensible but highly desirable, to avoid a very labour intensive exercise particularly if it submitted academics to a double assessment. So we propose to work to explore with the HEFCE whether we can conduct a common assessment exercise. I shall be meeting with Graeme Davies and his colleagues in the next few weeks to discuss this. In terms of the budget, the single funding stream to be created following Culyer will be held centrally and there will be accountability through the Director of Research and Development. We recognise the need for national co-ordination of major funding decisions and the new Central Research and Development Committee, which will be introduced early next year, will have a new function advising on how the budget is used to support national, regional and local research as well as the service support element. I believe there has to be a national and local balance. From the outset we have not seen NHS R&D as a programme driven exclusively from the centre. I think if it was to be driven from the centre it would take it too far away from the potential users of the output of the research programme and indeed those that are contributing information on NHS problems that ought to be addressed. The details have to be worked out about the budget. I envisage something along the following lines: that the Centre, advised by the Central Research and Development Committee, will continue to set and support national priorities including health technology assessment. That there will be responsive mode funding at the regional office level. That centres and units supported through the R&D programme, such as the Cochrane Centre and the York Centre, will actually be managed from the Centre, the contracts will be let and they will be managed from the Centre. That R&D outside the national priority areas identified by the CRDC, which is directed at problems identified by the regions, will be commissioned and managed from regional offices and (as set out in the paper *R&D in the new NHS*) there will, of course, be peer review and appropriate mechanisms for commissioning and managing regional research. That the research facilities support will be related to the research assessment exercise and be co-ordinated centrally.

Earl of Selborne

16. My Lord, I wonder if I could come in on research assessment. I think we recognise the scale of this problem. You have already reminded us that the scale of the work which has been undertaken is not known. There is much work still to be done to, first of all, quantify research being undertaken sometimes in a perhaps rather informal way and then it has to be assessed before the research can be commissioned or recommissioned probably on a regional basis. Could you elaborate a bit further as to how this initial assessment and indeed recording of existing programmes is to be undertaken?

(*Professor Peckham*) Well, I think that I cannot at this stage unfortunately give you any details about how that will happen because we are really quite early into discussions with partners. I have seen the MRC, I have seen the ABPI, we have not yet seen the charities, Committee of Vice Chancellors and so on and I have not yet seen the HEFCE. We are aiming at a research assessment exercise in 1996-97 the outcome of which will inform research funding relevant to facilities in 1997-98. We believe and agree with the Culyer Report that a period of stability is essential, that were we to implement the recommendations too rapidly it could have a destabilising effect on institutions. So there is a balance to be struck between a period of stability and a research review beginning to influence the shifting around of funds from 1997-98 onwards.

Chairman

17. A question which follows on from what you have said, of course, relates to the Thompson Review which was extremely valuable but looked essentially at what one might call research-orientated hospitals which were on any criterion well funded because of that research orientation in comparison with certain

[Chairman *contd.*]

others. How might these principles apply to the general participation of provincial teaching hospitals or their medical schools? How do you see that working out in future?

(*Professor Peckham*) As far as provincial teaching hospitals are concerned, this is precisely what an extension of the Thompson Review, and I use that but possibly and probably a combined exercise with the HEFC, would achieve. This would be directed at provincial teaching hospitals that work with medical schools. In terms of non teaching hospital trusts more generally, this has to be thought through.

18. Yes.

(*Professor Peckham*) I cannot give you a .pat answer to this. One of the important recommendations of Culyer is that the funds would follow good research rather than institutions. We recognise the importance of institutions but we also recognise that research funding has to extend into general practice. It ought also to extend into those general hospitals where there is an excellent focus of research and where there is an opportunity, perhaps because of the proximity of a university, to be opportunistic about developing something new. This has not been possible in the past.

19. On the face of it your own table two does indicate that more than twice as much money was spent on teaching and research on the expenditure in the London post-graduate SHAs (which we are all, it has to be said, anxious to see preserved) as was spent on the service of research across the rest of the country. This was a point that came out in that particular table.

(*Professor Peckham*) I would like just to qualify that. The amount of money that is allocated to the former SHAs covers not only the service support cost of research but also the total patient care costs associated with research.

20. One anxiety, of course, of many people following Culyer is what is going to happen when the regions disappear. I think there are three issues that I would like to raise with you. Have you any idea as yet, or is it still a matter to be worked upon, as to what proportion of the 1.5 per cent is likely to be devolved to regions? Secondly, I now speak as a former Dean of a Medical School; many years ago, if one identified what one might call a disaster area where the quality of teaching, research and very often patient care in a particular specialty was below what we felt would be appropriate one of the best ways to tackle that problem was to create a chair in the subject and to attract someone of high quality to come into that chair in order to raise the standard of teaching, care and research. It worked in a very large number of cases, particularly in what might be called the minor specialties. Many regional health authorities in the last few years have recognised the importance of this and have themselves funded chairs. What is going to happen to that kind of mechanism when the regions disappear?

(*Professor Peckham*) Perhaps I could tackle the second point first which was the academic post including chairs that are funded with NHS resources through the regions. This issue is, of course, recognised, there is currently a survey which is being carried out by our colleagues in the Finance Directorate in the NHS Executive together with regional finance colleagues to determine how much is actually being spent on academic posts, where and what those posts are actually engaged in. The results of this I think will provide a basis for considering what needs to be done after 1996 when the regions no longer exist and when regional money as such ceases. I think there will clearly need to be a solution but some of this may be a call on the R&D budget, some may be more appropriately covered by the teaching funding stream, and some of this may need to be covered from non-research, non-teaching NHS sources. That is, I think, where we are in looking at the funding of academic posts.

Chairman: Another anxiety, of course, is that the locally operated research scheme has been a very effective means at regional level for many years of allowing young doctors and young scientists working in the NHS to take their first steps in research by getting a small grant from the region to help them to carry out a minor project. Of course, Culyer, and your own proposals, seem to imply that you will not only have regional research and development committees but you will also continue a mechanism of having a scientific peer review committee to assess the quality of applications for such research grants at a local level. This then surely does imply that at regional level there is going to continue to be some funding for the locally operated research scheme. How is that going to be affected when regions disappear? There are a lot of anxieties about these problems.

Baroness Jay of Paddington

21. What will happen to the projects which have national significance determined at the national level and which up to now have been given to regions to take the lead in?

(*Professor Peckham*) There are a number of questions there. One is that, of course, after 1996 there will be a single centre, if you like, which will be composed of the eight, so far as R&D is concerned, eight Regional Directors of R&D working with my Directorate centrally. That will have to function as a single group. I believe that will add great strength to the national coherence of the programme. In describing the devolution of the R&D budget in an earlier question I touched on those aspects that we felt would be commissioned and managed locally from regional offices. Advising on the balance between national priorities and local priorities set by the regional R&D committees will be a new function of the Central Research and Development Committee; that will be a new and important function. In terms of the locally organised research scheme and the provision of small grants on a responsive basis, we envisage that responsive mode funding will continue in the programme. We believe that is important and the precise proportion of the distribution of these various budgets needs to be decided and I will be advised by the CRDC on that. For the regionally important priorities there will be scientific peer review which we want to separate from the regional R&D Committee which will focus on setting the R&D agenda and making use of the

[Baroness Jay of Paddington *contd.*]

research results. In terms of the question about national priorities, in the past, for example when we identified a nationally important theme such as mental health, the CRDC advisory group identified or advised on the priorities, the work was then commissioned and managed by a designated Regional R&D Director. The way in which national priorities will be handled in the future is still under discussion, in fact the Regional R&D Director group which meets monthly has been discussing this on several occasions and it really depends at least in part upon the balance of the staffing between the centre and the regional offices. The overall detail of that still remains to be worked out.

Chairman

22. So effectively you are saying that the new regional offices of the NHS Management Executive will be the bodies through which the regional mechanisms will continue to work?

(*Professor Peckham*) Yes. The emphasis of Culyer as the Regional Directors of R&D with their staff complement, which has more or less now been agreed as being the focal point for R&D in the enlarged regions, we would subscribe to that.

23. What mechanisms do you see as being likely to be helpful in promoting research in primary and community care? Again, I recall as a former Dean that we found great problems in being able to employ general practitioner teachers except those who actually undertook part-time contracts with the university as a lecturer or senior lecturer, because GPs are independent contractors. Here you have got a real difficulty in relation to funding for the infrastructure of GP research. How do you see this being overcome?

(*Professor Peckham*) A general point, that we had before the Culyer review recognised the importance of emphasising general practice or primary health care research. As you know, we have created a new centre for primary care research in Manchester on the basis of a national competition and that will be officially opened in early 1995. We have also identified the interface between primary and secondary care as one of the national priority areas. A programme of research is being commissioned in that area now. The support of both research and the service support aspects of research in primary and community care, is overdue and we see more clearly how that could be tackled through academic general practices, university based academic general practices, and community trusts. As you raised the issue of allocating funds to individual general practitioners that poses more difficulties. The funds that would support such a shift of emphasis, again we are considering how that will be addressed but one possibility of course is a contribution from the FHSAs and fund holding general practitioners and as I previously mentioned Ministers are sympathetic about ring-fencing further funds to enhance the research funding stream from 1996-97 onwards. It is fair to say that we have not yet solved the problem of how to actually support research by the individual general practitioner. I think that this is likely to be a slow process that will need to be built up over time. The research competence in general practice outside academic general practice is really not strong. I think we will need to work with the existing general practice research networks, such as the MRC network, and charity research networks to gradually strengthen this aspect of the programme.

24. Is there for instance a possibility that sessional time might be paid for from the research budget to enable certain GPs with the particular expertise needed to undertake research?

(*Professor Peckham*) Yes, I think that that possibility will need to be explored.

Baroness Jay of Paddington

25. It will need to include nurses and other people involved in care and not directly part of the medical structure.

(*Professor Peckham*) Yes.

26. It brings me to the point which Professor Peckham will know I have raised several times in CRDC, not on my own, it has been something many members have felt concerned about that there is a problem. I do not know whether there is anything in Culyer which suggests ways around this. There is a problem between those members of the medical community who are brought up in the whole ethos of research and obviously have research as their primary concern and people who are involved in health care whose contribution to the general health service research and development programmes is obviously vital but who feel in a sense that they are not sufficiently academic or are not trained appropriately or do not know how to ask research questions to venture into this water. There is also the financial problem of encouraging them and I think that is a fairly major difficulty.

(*Professor Peckham*) Of course I recognise this and the use of the term primary health care emphasises this is not simply a general practice issue. It extends beyond that to include the entire primary care team. We have been concerned to emphasize the multidisciplinary nature of the programme. We have established a nursing research task force which has reported and which is being implemented. We have been working with the therapy professions as well. The regional directors have in fact built up a fellowship programme over the last couple of years and there are now some 159 fellowships that are supported through the regional NHS R&D programme, a substantial number of which are non medical and non dental reflecting our attempts to stimulate research training in other specialities.

Chairman

27. How do you feel that the Research Liaison Committees have functioned: in cancer, cardiovascular disease and stroke, etc.? What have they achieved in practical terms? Your own memorandum suggested that their role has been limited. It follows really that we would like to have your views upon what role you see for the national forum that the Culyer Report has proposed over and above that of the Central Research and Development Committee. What do you see as being the role of such a forum and will it be more effective than these Research Liaison Committees?

[Chairman *contd.*]

(*Professor Peckham*) We have established three Research Liaison Committees, one in respiratory disease, one in cardiovascular and stroke and one in biomedical technologies. It seemed important to bring major funding bodies from the private and publicly funded sector together with the NHS to look at or better understand respective strategies and priorities, to look at the opportunities for joint working, even for jointly funded projects, and then to look at some more generic issues such as the conduct of multi-centre clinical trials, and the whole issue of research training and career structure. I think the respiratory and the cardiovascular Research Liaison Committees have been very useful in familiarising the participants with their respective programmes. The Biomedical Technologies Committee led to the formation of the NHS Industry Research Advisory Group which is soon to report. The Research Liaison Committees have also allowed us to present NHS research priorities to the charities and to the MRC. This has been quite effective. The MRC has funded a number of NHS priorities and the cancer charities are considering the recently reported NHS cancer priorities. However, some of the generic issues clearly need to be addressed not by bringing disease specific funding bodies together but at more national level. In Research for Health in 1993 we indicated our intention to establish a National Health Technology Forum. The reason for that was to focus on clinical trials and to focus on the whole business of health technology assessment which many agencies and funding bodies were engaged in but not in any co-ordinated fashion. That has been overtaken by the Culyer recommendation to create a National Forum. I believe this is a very important recommendation and I would like to see a National Forum in place in the first half of 1995. This is indeed what we are discussing with MRC, with industry and with the charities. I can say that the Association of the British Pharmaceutical Industry has been very positive about this proposal and would like to participate in it. I see that the value of it is being able to really understand what the respective strategies of funding bodies may be. It will provide an excellent basis for identifying emerging technologies, and growth areas of science and technology that each funding body will know about which are likely to impinge on the health service. It will allow us to look at issues such as career structure and clinical trials.

28. How could you ensure then that the National Forum is so constituted as to be a body with not only expertise but also authority and not just a kind of talking shop?

(*Professor Peckham*) The National Forum I would see as a representative body whereas the Central Research and Development Committee would represent interests and reflect interests but not be representative of organisations. We have always sought to emphasise the importance of a Committee that was advising on national priorities and now on funding, that that should be composed of individuals with a broad coverage of interests. So the National Forum would have considerable influence. It would feed into the new Central Research and Development Committee, for example, but as a committee of representatives of funding bodies I would see its advisory function focusing on generic issues and informing CRDC discussions.

29. It is, of course, absolutely right that priorities for medical research and many other issues that we have discussed this morning should be determined nationally. One anxiety that I think some of us have is that we opposed in principle the idea that universities should be divided into so-called research and teaching organisations. The reason why we opposed that was because you can never quite tell in which area the new star with original ideas is going to arise. All too often in Departments and subjects that may not be looked upon as being exciting in research terms somebody suddenly comes up with original ideas and developments which turn out to be quite exciting. Who would have thought, for example, that one of the earliest pieces of work on hip replacement would be done in a provincial hospital in Norwich? There are many, many other examples that one could quote over the years. Is there a danger, if there is I am sure it is one of which you are fully aware, that the national determination of priorities and programmes might impair the ability of certain medical schools and regional hospitals to develop areas of research in which they show particular expertise?

(*Professor Peckham*) I think that I have never envisaged the identification of national priorities as a top down process. The challenge for us is to actually capture what the NHS staff, the clinicians, the managers, the nurses, see as problems, encounter as problems, to capture that and then in conjunction with those who have competence in research begin to formulate those problems as research questions. This interactive process is carried out through the Central Research and Development Committee with researchers invited in open competition to submit proposals to tackle clearly specified problems. I believe that that corrects a deficiency which the House of Lords' Committee identified of a lack of research directed at specific health service problems. That goes side by side with clinical research, and curiosity driven research, and they are entirely complementary. I have not seen that as any kind of straitjacket which inhibits the bubbling up of new ideas or new research. I think this is something that must be supported strongly in the programme. For example, the Standing Group on Health Technology not only has a remit to advise on those health practice methods that really do need assessing and assigning some priority but that is a huge problem because when we consulted with the health service we had 1,400 priorities proposed. The idea of conducting 1,400 clinical trials makes the mind boggle, it is a big problem. Not only does it have that function but it has a function of advising on new emerging technologies, health practice methods, treatments, and I think this latter remit and the relationship between the NHS and the science base is a very important aspect of the R&D programme. The purpose is to identify new developments that are likely to impact on the NHS over the next two, three, four years. Perhaps in parenthesis I could add that we are meeting with the OST, the Office of Science and Technology Health Foresight Exercise, a group chaired by Professor Mark Ferguson. This establishes a connection with a longer term

[Chairman *contd.*]

perspective of new research bubbling up with significance for the health service.

Baroness Jay of Paddington

30. Given what you have just said would it not be better if there was some stronger NHS purchaser representation in the Forum?

(*Professor Peckham*) The recommendation of the Culyer Report is that in constituting the new CRDC not only are the interests of the research councils and charities reflected but there is stronger input from the NHS, including purchasers.

31. Should that not also be reflected in the Forum?

(*Professor Peckham*) I think there is a difference between the responsibilities between the two bodies. I would see the NHS input into the CRDC being more crucial particularly with input from the networks being established by Regional Directors of R&D. This will help to fulfil the function of advising on national priorities. The terms of reference are yet to be worked out following discussion with our collaborators but I would see this as being predominantly a forum of the research funding bodies bringing together industry, the research councils and the charities.

Earl of Selborne

32. In rather crude terms it seemed to me that one of the purposes of setting up the National Forum was to ensure that the other funders of research were put on level pegging with the MRC who have the Concordat, which is thought to be an inside track on getting the necessary support services. Am I over-simplifying that or do you see that as one of the objectives of the National Forum?

(*Professor Peckham*) I think that this is an area of discussion that the National Forum is bound to have and we have already begun with the Medical Research Council. The new Concordat in 1992, due to be reviewed next February, gives a pretty open-ended commitment by the NHS to support clinical research of the Medical Research Council. I think it is fair to say that in our preliminary discussions with the MRC they recognise that the commitment cannot be open-ended, we have to consider and think carefully what is meant by the support of MRC clinical research in relation to support of charity research. That needs to be worked out. However, we do have a very formal relationship with the MRC in which we are committed to supporting their clinical research but they also have a commitment to address and tackle priorities identified by the Health Departments and this is a very interactive process with an annual stocktaking meeting and also regular officer level meetings throughout the year. It is also implied in the Concordat that the Department of Health, or indeed the Health Departments more generally, need to become familiar with the total portfolio of the MRC, not just the applied research portfolio but the more basic aspects of their research portfolio, and for that reason I am on the Science Strategy Committee of the MRC. There is a very special relationship. In our discussions with charities we shall be considering what kind of "Concordat" might be developed between the Department of Health and the major charities. Those discussions are still to be held.

33. It is clearly desirable that the NHS and the MRC should have as much mutual understanding of each other's activities as possible, that seems to be quite important. Do you think that the creation of a National Forum will require, therefore, the existing Concordat to be revised?

(*Professor Peckham*) I think the existing Concordat will need to be revised even if there was not a National Forum. We are due to have a formal review of the Concordat in February next year and there will be a renegotiated Concordat in 1997; that was agreed when we produced the revised Concordat in 1992. One of the issues that has come to the fore over the last year particularly has been the service support of MRC clinical research and the way in which clinical trials are brought to the attention of the health service and it is clear that there is a need to anticipate the service support, indeed calculate the service support requirements, of MRC trials. It is recognised by both the MRC and ourselves that needs to be worked out. A new Concordat would certainly be addressing those issues.

Chairman

34. Your suggestion that the possibility may arise of entering into a Concordat with charities is most welcome. Perhaps I should declare an interest as a former member of the MRC but still as Chairman until next year of a major research charity. Could I just take up one point which follows from what you have said. The transfer of funds from the universities' budget relating to the infrastructure of research carried out with grants from the research councils, we were assured, was a transfer which related solely to the infrastructure of research council funded work. For that reason my understanding is that the universities have, for the present at least, decided not to charge overheads to charities which are funding research. May we take it that this same problem is one that in your discussion with charities you will be examining with care when you look at the infrastructure of charity funded research?

(*Professor Peckham*) Yes, that will have to be part of our discussion.

35. Can I then go, just for a moment, on to the issue of teaching. The suggestion has been made that in the current allocation of SIFTR, the allocation is something like, in medicine, 75% teaching and 25% research. Is there any firm basis for that conclusion or is this just a conjecture? How does the situation compare, for example, with dentistry where it has been suggested to us that because of the very heavy teaching load in dental hospitals the allocation there is much more like 95 per cent teaching to five per cent research. What do you feel about the difference between medicine and dentistry and do you have any basis for determining how that breakdown of SIFTR can be achieved?

(*Professor Peckham*) This is an issue which has been addressed by the Standing Group on Medical and Dental Education and Research which is chaired by the Permanent Secretary which has looked at the basis for the allocation of SIFTR starting with an

[Chairman *contd.*]

attempt to see whether the research element could be allocated in relation to research activity in the early 1990s and then it looked at the sub-regional distribution of SIFTR and more recently it again has commissioned an econometric study to see whether the breakdown between the "R" and "T" elements of SIFTR could be made more precise and how the "R" element might be allocated. We anticipate an announcement on this soon—this has quite recently been discussed—including the proportionality between R and T. It is difficult for me to comment further at this time.

Lord Nathan

36. This is from whom?

(*Professor Peckham*) An announcement from ministers.

37. From ministers?

(*Professor Peckham*) Yes.

Chairman

38. Turning from teaching then to training, according to Research for Health you are discussing with the MRC and universities, charities and other organisations the whole issue of research training for careers. You may or may not be aware that it is the intention of the Select Committee of this House, its second sub-committee will be looking in a future enquiry at the whole issue of academic career and research careers as a matter of some importance. This Committee, however, was concerned in 1988 that medical research was not an attractive career particularly when compared with medical practice. We are all aware now of the fact that there are grave concerns about the future of academic medicine because of the many disincentives that arise in academic medicine in comparison with the incentives of medical practice in the NHS and of course in private practice. The situation does not seem to have improved and Culyer shares the anxieties we expressed about that. What are you hoping to achieve in relation to training for research and medical research careers, not just for doctors but for scientists working in association with doctors and other health care professionals?

(*Professor Peckham*) I think this is precisely the sort of issue that the National Forum will address. Certainly we are very concerned to persuade our partners to expand their programmes, offering research training to clinicians and to scientists engaged in clinical research. There will thus be an opportunity to do this in early 1995. In terms of our immediate area of interest directed towards stimulating the neglected area of health services research including operational and economics research, we have taken some steps to strengthen research training and career structure. An independent review of the 13 research units supported by the Department of Health was published in 1992 (the Williams Report). Following the recommendations of the report we took the decision to create the first of a small number of new R&D centres. The first new centre has been, as I have previously mentioned, awarded to the University of Manchester for primary care research and that is a substantial commitment of funds over a ten year period which is aimed to create a critical mass of researchers in a neglected area and also to try and create a multi-disciplinary group in health services' research actually based in the university setting and to give added value both to the work of the centre and to the university itself. That is one development. A second is that we are working with the MRC to create joint MRC/NHS fellowships which are again focusing on health services' research. These will be predominantly medical fellowships in health services' research. Through the Concordat (where we are able to express what we see as important areas to address to the MRC) the MRC health services' research initiative which has recently been awarded to the University of Bristol has been supported as an important development. That will actually focus on two aspects which are complementary to the NHS programme, one is research methodology in health services' research and the second is training. As I previously mentioned the Regional Directors of R&D have identified research training as a high priority area themselves. They have created a substantial number of fellowships. In a snapshot view of this, which is now current, which I just received, there are altogether 159 fellowships and studentships, of the fellowships 49 are in medicine or dentistry, 74 for other staff; and in terms of PhD and M.Phil studentships there are 36, of which 21 are in medicine and dentistry and 15 in other specialties. So that is quite a substantial commitment. The R&D programme has also had a stimulating effect with the creation of centres funded by the NHS in conjunction with universities. For example, in Trent, the three universities of Sheffield, Leicester and Nottingham have joined with the NHS region to create an Institute of Health Services Research. There are several other initiatives of that kind going on. Finally, again through some of the activities of Regional Directors of R&D industry has funded a number of academic developments. For example, in conjunction with Professor Breckenridge, Glaxo has funded a chair in pharma-economics in the University of Liverpool. These are beginnings. We recognise that research funding and career structure is an extremely important problem and something which we need to give a lot of attention to and where I would look to the National Forum to be the forum in which we actually progress this.

39. It is very helpful and encouraging that the training opportunities are increasing. These are no doubt short term fellowships, time limited, not career posts of any kind?

(*Professor Peckham*) Yes but some of the other initiatives such as the Manchester Primary Care Centre and the Trent Centre of course will tackle or begin to contribute to a career structure. A more general issue, if we can take forward the recommendations of Culyer in the way in which we would like to do it, then we would anticipate that the new arrangements will be a very powerful mechanism for enhancing quality of work and support for research centres. I hope that this will contribute to clinical research.

40. Of course, apart from the MRC we have all recognised the value in clinical research of, for

[Chairman *contd.*]

instance, the Wellcome Trust's senior clinical research fellowships and senior lectureships which have made a major contribution. I recall again looking back to my deanship that I was able some years ago to persuade a major trust in the North East to endow research lectureships in clinical science to be held by scientists working in clinical departments which were competed for throughout the entire medical faculty. These were long term career research posts; those again are the kinds of things the National Forum may at least look at in collaboration with other funding organisations. One of the greatest difficulties of all is that the scientists who work alongside the doctors contributing to research are all too often working from short term contract to short term contract. I am sure the other sub-committee will be examining this in depth.

(*Professor Peckham*) I recognise the problem.

41. Could I then ask you about operational research which is examining the effectiveness of service provision and NHS administration as opposed to biomedical research. Can you tell us where you would identify centres of excellence for such research and whether the scientific base for such research has expanded since you started work?

(*Professor Peckham*) I wonder whether I could just briefly describe the scope of NHS R&D because I think there may be a terminological issue about what we mean by health services' research, what might be meant by operational research and so on.

42. Yes.

(*Professor Peckham*) Very briefly, the scope of the NHS R&D programme, firstly we are concerned with mobilising existing research information and using it. We have created the Cochrane Centre in Oxford and the York Centre for Reviews and Dissemination which now includes a cost effectiveness register, a register of all cost effectiveness data published in all the literature. The second aspect is generating new research information, which we have done in relation to diseases, mental health, cardiovascular disease and so on, cancer most recently. It has also been done in relation to client groups. We are about to complete a priority setting exercise in maternal and children's health and we have commissioned a programme of research on issues relevant to the physically disabled. There is a strand, as yet to be fully exploited, on consumer issues but we have now taken steps to tackle that. The remit of the Standing Group on Health Technology includes the development of research methods. Finally, a focus on management and organisation issues and management of organisation of services. The first initiative was to look at priorities in the area of primary/secondary care interface which was a crucially important area. We have looked at the purchasing functions of the NHS and the research issues surrounding that. Research priorities are also being identified by the Directors of the NHS Executive Board. Just to give you an example of three that have recently been identified. One is what do we know and how do we approach the problem of the optimal organisation of accident and emergency services? Secondly, how do we determine, or how can we determine, what could safely be transferred from secondary to primary care? Thirdly, what is the relationship between the volume of clinical work—number of patients treated - and the outcome of care. Is it true that the more patients treated in a hospital the better the outcome? What is the validity of that commonly held assumption? These are very operational issues so that research into the mode of operation of the health service is very much an integral part of the programme. If you look at more conventional operational research techniques which use either quantitative or qualitative modelling methods, then in fact we support, as far as I know, the only operational research unit into health in the country which is the Clinical Operational Research Unit at University College. That has had a recent very successful site visit and we will continue to support it. It has, for example, been modelling issues such as cervical screening and how you handle mild dyskaryosis, do you proceed with colposcopy or follow up cytology and you can model that and you can come out with some very valuable conclusions as to the way to proceed. Another thing that they model is ultrasound in antenatal screening, cancer chemotherapy and so on. That is the operational research in its industrial mode, if you like. An important link is with the Economics and Operational Research Group in the Department of Health. We work closely with this group and in fact we are developing a postgraduate training programme in health operational research and health services research combined.

43. Is any research being done into the way in which the NHS is administered?

(*Professor Peckham*) I need notice of that question.

44. Perhaps you could think about it and write to us afterwards.

(*Professor Peckham*) I will come back to you.

45. Thank you.

(*Professor Peckham*) I may add, while I am thinking on my feet, that I believe that under our management and organisation of services perspective, certainly different models of management really ought to be susceptible to R&D in the same way as different models of delivering clinical care might be. The intention is there. I might add too that in relation to the recent announcement about the extension of GP fund holding, as that develops I am sure R&D will be there looking at how models of GP planning might be set in place and how it might be evaluated.

46. Thank you. In Research for Health you indicated that you would wish to see managers being trained more effectively in an understanding of research techniques and research objectives. Do you envisage managers beginning to acquire a sense of ownership of the research activities in their hospitals, leaving aside for the moment short-term value in purely financial terms?

(*Professor Peckham*) I could start responding by saying that I believe that my membership of the NHS Executive Board has been important because it has presented and enabled me to present a research perspective on every conceivable occasion in discussions that are primarily orientated towards management. I think it is fair to say that the senior managers of the NHS are now conversant with, and

[Chairman *contd.*]

I believe convinced about, the value of having R&D as a core function of the NHS. Indeed I think that in retrospect it would seem unthinkable that R&D should not be a core function of the health service. Of course the present chief executive of the NHS, Alan Langlands, and several other members of the NHS Executive Board were founding members of the CRDC. The impression is sometimes given that managers in general are only interested in short term results and not interested or even aware of the need to commission medium and longer term research. I have to say that I have not found this in my discussions to be a general theme. I think people understand perfectly well not only the value of research *per se* but the value of the conduct of research in attracting high calibre staff to their institutions and that is a very important issue. Having said that I believe that we have to deliver in the short term, which is why we put so much emphasis into mobilising research results. At the same time there is a need to commission clinical trials and support longer term research. In terms of what we have done in practice there are several initiatives that are now expanding quite rapidly which closely involve managers. Perhaps the one that goes under the acronym GRIP—Getting Research Into Practice—which has been developed in Oxford has been very influential. This is essentially taking research information, including data from the National Perinatal and Epidemiology database of effective procedures in pregnancy and child birth and introducing those into the commissioning process between purchasers and providers. That is being done in four health authorities and has had a very stimulating effect on the perception by managers of how research can change things and indeed if you can do this for one piece of work why can you not do it more generally. There is a range of initiatives along the lines of GRIP now happening around the country which involve managers. Regional Directors have set up a number of critical appraisal courses for NHS staff including managers and in one region, for example, one to one arrangements have been explored for taking managers through a process to try to disaggregate a problem and present it as a potential research proposition. Just to move away from managers for a moment, some of the R&D concepts are now feeding into the training programmes of the Royal Colleges, for example the Membership Examination of the Royal College of Surgeons. In conjunction with the NHS training division, with the Institute of Health Service management and the Wellcome Trust, we are developing workshops for purchasers, to promote an understanding and appreciation and receptivity to research. I would very much like to introduce R&D in a formal way into the training of NHS managers. A lot of us spend a lot of our time talking to groups of managers about research. I think that starting from a very low base there is now quite a lot of activity in this area. Finally, can I say that we are about to set up a group that will look at research into education. This is not about research training or research career structure but how should our programme perhaps influence undergraduate education, postgraduate education and continuing education. I hope that that is set up very soon.

47. I presume that the regional structure you have established would allow you, should the need arise, to carry out experiments in different regions to compare various means of delivery and assessment of the results of R&D?

(*Professor Peckham*) Yes, indeed. I think that in a more general way we should take advantage of variations in the NHS to actually see this as a test bed for a range of applied research issues.

Earl of Selborne

48. The Task Force aspires to give primary and community sectors equal access to research and development funds and associated service costs, always assuming that the research is relevant and follows a clear protocol. What procedures can be adopted in order to assess just what is relevant within the primary and community sector and how this is brought into parity of assessment, peer review and indeed determining its relevance?

(*Professor Peckham*) When you say what is relevant, there are perhaps two ways of looking at it, one is what is going on and being conducted now in the primary care setting, but the question that would be more pressing from my point of view is what we ought to be tackling, we ought to be addressing. We have actually put quite a lot of effort into this. We did, for example, set up a group which has written, the report has been published and is now a commissioned programme of work, exploring in some detail the issues important for primary care particularly in relation to the interface between hospital and the primary care setting and the way in which that is changing. There, using the criteria that we followed for prioritising other areas, predominantly of hospital interest, we came out with a set of priorities in which, for example, very high up on the list was information flows between the hospital and the primary care sector in both directions as being something which really requires a lot of emphasis and requires an investigation. In terms of what is relevant in primary care and community care I think that is susceptible to the same kind of analysis as what is relevant in the acute sector in the hospital setting. Of course, increasingly to divide the two is artificial. If you take minimal access surgery where patients come in overnight and they go out the next day after, for example, having a gall bladder removed, it would be inappropriate simply to look at the hospital end of that problem or indeed the primary care end of the problem, it is a continuum and one would have to look at both aspects if one wanted to investigate minimal access surgery, in my view. Those are just general points relating to the identification of problems in the primary care setting. How, having identified the problems, we tackle them is another issue. In many cases, the research groups that are competitively bidding for funds to tackle primary care problems will not be in primary care, they will be based in a university, for example the new Primary Care R&D Centre at Manchester. That is fine, we would like to see that increase. The bigger challenge for us is actually to take research into the primary care setting itself where it does not happen very much. That is the intention. We believe it is very important, there is a

[Earl of Selborne *contd.*]

lot of thinking to be done about how we do it, how the problems can be overcome, particularly at the individual general practitioner level.

Lord Nathan

49. How far do the costs of the ultimate treatment to emerge from successful research programmes enter into your assessment as to whether or not that research should be carried out? Of course we all have in mind the increasingly complex transplant arrangements, cochlear implants and so forth which have been most successful. Is there any point at which you would say: "We cannot finance research on this matter, vitally important though it is, because the cost of carrying out treatment will be beyond the means of the NHS" although, let us be clear, it might not be beyond the costs which would be affordable in the private sector? So it might have merit but would just be constrained by the NHS budgets.

(*Professor Peckham*) I believe this is actually a very fundamental issue which is that if we are, for example, to support a trial which compares an existing treatment with a new treatment, the new treatment may or may not be better but it might be more expensive, then the issue arises as to who covers the cost of the new and experimental treatment during the evaluation process itself and then following that in its entry into the health service? We are giving a good deal of thought to this problem. I think that without going into that in any detail we would expect those responsible for purchasing care to be responsible for purchasing the patient costs of that new form of treatment with the R&D budget being called on for excess costs. But, it seems to me to go specifically to your question, that if we are really to involve the health service in research then those who will be responsible for purchasing an important service that might come out of that trial, that evaluation, will have to be made aware that it is happening and will have to be prepared to actually purchase that if it proves to be better than existing treatment. This means we have to have an early dialogue with purchasing managers and so on. This has not happened in the past but it is, I believe, just beginning to happen. I hope that that answers the point that you are raising that if there is a new expense, and this is now happening very much with new bio-pharmaceuticals, many of which have not been evaluated for their comparative effectiveness or efficacy, if that happens then I think we must work with those who will be responsible for purchasing it right from the outset of the evaluation.

Chairman

50. That is a helpful response because years ago it was decided, and it must be 20 or more years ago, that cardiac transplantation was too expensive for the NHS to afford but then, of course, much more recently health care economists have done some very careful analyses and discovered that in fact it is an extremely cost effective form of treatment in NHS terms.

(*Professor Peckham*) The cost and benefits of cardiac transplantation was one of the very early studies carried out by Martin Buxton and his group.

51. Exactly.

(*Professor Peckham*) I think that the business of measuring the cost effectiveness of procedures is in its infancy. One of the areas that we have to give emphasis to is health economics.

52. Yes. Lord Nathan has raised a fundamental point. The medical and research community would undoubtedly throw up its hands in horror if it were to be told that it could not carry out a particular piece of research because of the potential outcomes and costs that might ultimately be involved.

Baroness Jay of Paddington

53. You mentioned the obvious importance of you being on what was the ME, now the National Health Service Executive, and as it were educating those at the centre about the importance of R&D. Do you have any thoughts about the way in which your own post and your own Directorate at the centre might develop?

(*Professor Peckham*) Yes. There has been a review of the wider Department of Health carried out by Terri Banks in addition to the functions and manpower review of the NHS. That has not yet reached its final conclusion so we are unable to make any firm statements about the staffing of the Research and Development Directorate centrally in Leeds. It is fair to say that the review itself noted that the Research and Development Division was one of the few overarching activities of the Department of Health covering both a wider departmental remit as well as the NHS. Optimistically I anticipate that we will have a critical mass of staff in Leeds to work with regional staff. In terms of my own post, I came on secondment initially for three years, extended by two years, and that comes to an end in 1995 and I have formally indicated that I will relinquish the post at the end of 1995. I anticipate before that before too long a search will be undertaken for a successor.

54. Thank you very much.

(*Professor Peckham*) Could I just add one point to the response stimulated by Lord Nathan's question concerning the importance, I think, of working with those responsible for paying for health care. In the past there is no doubt that they have been presented often abruptly with expensive new treatments and I do not myself think that there is any reluctance to face up to the issue but it is very important to take it on board. The academic community and the clinical community has to play its part and too often in the past a new method has been superimposed on an old method without the old method being removed from the service, for example imaging, and this has happened right the way across medicine. It is very much in our interest to see that what is being superseded by the new treatment is actually removed if it is no longer needed.

Chairman

55. Thank you. Fortunately, the setting of priorities in relation to the treatment of the individual does not fall within our terms of reference, but equally it is important that we should be aware of the various dilemmas that face the medical and

[Chairman *contd.*]

scientific community. Professor Smith, is there anything you would wish to add at this stage?

(*Professor Smith*) I would like to add in relation to the Culyer Report, a lot of the questions have been what are going to be the consequences of the Culyer Report. I think it is quite important to grasp, as we understand it, Culyer is recommending a framework for making many decisions. I do not think Culyer gives an answer but what it does is it gives a framework and a way of addressing these issues which very often have not been aired before. On many of the issues which I think have been raised today there was great difficulty in addressing those questions and coming up with a clear answer previously because we did not have the structure and the framework to do that. We hope that as we take Culyer forward we will now have a structure both through the Forum and the CRDC and the decisions which have to be made about funding streams, but a lot of issues we could not address before we will now be able to and have therefore a much more informed and coherent debate.

56. Thank you, that is again helpful because one of the reasons why this Committee decided to pursue this enquiry was because it was felt Culyer, admirable though it was in many respects, left a great many unanswered questions. We are going to do our very best to explore these. In the meantime let me say, that as your structure begins to evolve we would welcome being kept informed about how it will evolve because this will undoubtedly enable us to reach more informed conclusions at the end of the day.

(*Professor Peckham*) Thank you very much indeed for inviting us.

TUESDAY 22 NOVEMBER 1994

Present:

Butterfield, L.	Selborne, E.
Nathan, L.	Walton of Detchant, L. (Chairman)
Nelson of Stafford, L.	
Perry of Southwark, B.	

Memorandum by the Medical Research Council

1. INTRODUCTION: THE ROLE OF THE MEDICAL RESEARCH COUNCIL

The mission of the MRC, as set out in its new charter is "to promote and support, by any means, high-quality basic, strategic and applied research . . . in the biomedical and other sciences, with the aim of maintaining and improving human health." The MRC's programme of research therefore encompasses human biology at all levels and ranges from studies of molecules, cells, organs and systems to research on individuals and populations in relation to the environment in which they live and work. The Council has a special concern and responsibility in relation to the national capability for medical research (both basic and applied) and for capitalising on scientific opportunities.

2. THE CONCORDAT WITH THE HEALTH DEPARTMENTS

As the main publicly funded body for medical research the MRC has a special responsibility, reinforced by the White Paper, to work closely with Government Departments especially the Health Departments and with the NHS and to take account of their needs. Formalised in the Concordat (most recently revised January 1992), the MRC and the Health Departments have agreed partnership arrangements for promoting, funding and managing medical research in the UK. Provision is made for the Health Departments to have an input into the development and determination of the MRC's research strategies and funding decisions. In recognition of the fact that the clinical work of the MRC would not be possible without NHS patients, the Concordat states that "it is the policy of the Health Departments to ensure that, provided that adequate notice is given to the NHS, the funding of the NHS and the policies of purchasers and provider units continue to make provision for the necessary service support for that research supported from MRC funds." This records a commitment which has existed since the 1950s. The Council's commitment to meeting its Concordat obligations is illustrated in the attached publication: "HD Priorities—the research response" (*not printed*).

3. NHS R&D STRATEGY

The MRC welcomes the effort that has been devoted to developing a strategy for research and development for the NHS which corrects the deficiencies noted by the Select Committee at the time of their previous enquiry.

The R&D Strategy has been ambitious in trying to develop a new culture within the health service so that decisions become increasingly based on accurate knowledge gained through research; this requires the recognition of research needs, that the necessary research is undertaken and that the results are disseminated and incorporated in practice. The very wide consultation programme that has been undertaken to identify research needs has succeeded in raising the awareness of R&D throughout the NHS and of the extent to which it might usefully contribute to solving service problems, and thus to developing a knowledge-based service. The need to translate service questions into relevant research questions has been recognised and this is one of the areas in which the Council is conscious of the benefits of constructive collaboration. The different perspectives that the NHS has been using to review research needs (eg disease burden, organisation of services, the needs of client groups) have been effective in identifying a number of potential priorities for research. The articulation of needs has—as might be expected—highlighted a variety of short-term applied research questions. However, the development of mechanisms to produce research results of long term value to the NHS, in terms of efficient and cost-effective use of resources is also important, and this will involve increasing readiness to think in terms of the longer-term research needed to answer some questions.

The development of Regional R&D structures, including the appointment of Regional Directors of R&D, has led to greater regional awareness of the problems which would benefit from research and a more limited impact at local purchaser and provider level. There has been some progress in recognising the need for more effective mechanisms for the dissemination of research results and the need to incorporate new developments of proven effectiveness and efficiency into practice more rapidly. This is an area where the Council is playing a useful role.

The development of an effective information systems strategy is of key importance in the promotion of "knowledge-based, evaluative NHS" and effective progress has been made in providing information that was previously not readily available. The UK Cochrane Centre—and the international collaboration it has established—will provide systematic reviews of evidence from randomised controlled trials which are likely to be valuable to the research community, and to strategic organisations needing to define research priorities, as well as to the NHS.

The need for training in research methods for clinicians and for those engaged in health services research and in critical appraisal of research for those concerned with implementing research findings in NHS practice—whether providers or purchasers—has been recognised and is starting to be addressed. The Council's role is considered to be primarily in relation to those who will be career researchers and research training in health services research is being expanded by joint fellowships with Regions and by the provision of other research training and career development opportunities.

The consultation arrangements laid down in the Concordat between the Health Departments (in England, Scotland, Wales and Northern Ireland) and the MRC are designed to ensure that the MRC and NHS R&D programmes develop on a complementary basis, each organisation using their practical skills and experience to best effect in areas of common interest. The MRC is currently developing an Initiative in health services research (HSR) to complement other Health Department initiatives, The MRC Initiative will provide a further expansion of MRC capacity to support HSR in the UK. The emphasis will be on research into methodology underpinning HSR, further applied HSR and on training and career development. The spectrum of the Council's portfolio of research—from basic biomedical research to applied health service studies—is important for ensuring that future health service applications can be identified from basic developments at an early stage.

4. Impact of NHS Reforms: The Internal Market

Purchasers are required to make judgements on the quality and cost of clinical services and hence on their value for money. The development of the purchasing function therefore offers exciting opportunities to widen the interest in and commitment to R&D within the NHS so that well-informed judgements in purchasing are made and the process of disseminating information about best clinical practice throughout the service is encouraged. A drive for the "best" and most cost-effective therapy should indeed serve as stimulus to R&D activity.

On the other hand it is difficult for purchasers to take on board the needs of research where the benefits are often medium or long-term and are for the NHS as a whole rather than for individual patients, or for the patients in a particular locality. In an NHS market where there are no special arrangements to provide for the clinical service needs of teaching and research there will be (indeed are) threats both to the support for particular research programmes and to the long-term survival of high-quality academic institutions. Scientific developments are increasingly pointing to the importance of bringing together biological and clinical scientists in a multi-disciplinary environment within a clinical setting to ensure that major advances in the biological sciences are implemented to the benefit of clinical practice. The patient needs of these special centres will not necessarily mesh with purchaser contracts. Special arrangements are therefore necessary to ensure that purchasers accept a responsibility for the longer-term health of the NHS by placing contracts in such a way as to ensure that there are adequate patient flows for research needs, in addition to the development of funding arrangements to provide for the necessary service support. Similar considerations apply in primary and community care settings.

Following the introduction of the internal market the MRC has indeed faced a number of problems in obtaining NHS service support for MRC-funded research, in particular for some important multi-centre clinical trials; examples of these problems were presented in evidence to the Culyer Committee (paper attached). Whilst most of these problems have now been resolved on an individual basis following representations by the MRC and interventions from the DH Director of Research and Development, other problems are continuing to arise. The MRC's experience over the last two years has exposed serious weaknesses in the present arrangements for handling NHS service support for research; MRC proposals for addressing these issues were submitted to the Culyer Committee (section 5 of the paper attached).

The Report of the Culyer Committee has now been published. We welcome the recognition of the effects of the NHS reforms on the existing arrangements for service support of research:

- cost pressures forcing health care providers and purchasers to take a short term view and making them less inclined to invest in R&D;
- the erosion of the clinical research base;
- purchasers becoming reluctant to pay for the service costs of procedures being evaluated;
- the increasing tendency not to fund tertiary referrals on which much R&D depends and to support local service providers rather than send patients to major research centres—so putting independent evaluation at risk.

We also welcome the recognition of the problems created by the lack of a formal mechanism for the funding of the service costs of research for those in primary care and district general trusts.

In publishing the Report the Secretary of State said that she welcomed the broad thrust that

- funds for R&D and for the service support for R&D are marshalled coherently and separately from funds for other activities;
- those who perform R&D should justify their claims on resources, do so in competition with others and be accountable for the work they do;
- the primary and community sectors should be on an equal footing with the acute sector in terms of access to funding for both R&D and associated service costs.

We warmly welcome these same general principles.

There is indeed much in the Report that we agree with both in terms of the analysis and the recommendations. We attach particular importance to the recommendation that the single funding stream should be conceived as a levy on all health care purchasers' allocations and determined annually. We also share the concern that bureaucracy should be kept to a minimum so that the system does not continue to act as a discouragement to clinical researchers; we hope that this will be achievable in practice and recognise that clear guidelines/procedures will be required.

Whilst in no way detracting from our support of the general principles, there are two main areas where we part company with the analysis in the Culyer Report:

- the recommendation that the terms on which the NHS provides service support for MRC-funded research should be reviewed, in particular the argument that the existing commitment in the joint MRC/Health Departments' Concordat is too open-ended and that the NHS should not be obliged to support MRC research if it has good reason to believe that it has a better use for its money. We accept that from a Health Department perspective the present wording of the assurance in the Concordat on service support for MRC research is not ideal and we are ready to enter into discussions about refining this wording. However, we are disappointed that the Culyer report does not appear to take full account either of the MRC's position as a publicly funded body working in partnership with the Health Departments or of the arrangements by which the Health Departments already influence the MRC's strategy development and funding decisions.
- the absence of any proposal for protecting tertiary referrals which are crucial for many research teams in establishing an adequate patient base.

5. Impact of NHS reforms: London reorganisation

The MRC welcomed the Tomlinson review because of the opportunities it offered to rationalise and strengthen medical research and education alongside the changes necessitated in clinical service. However it was clear that these opportunities would only be realised if there was:

- joint planning, involving three Government Departments (Health, Education and Office of Science and Technology), to ensure research needs were integrated with service needs, in order to create centres in which clinical research and teaching could be closely allied with service;
- robust plans for implementing changes;
- commitment to implementing these plans within a suitable (short) timescale;
- associated with this, a commitment to the necessary capital resources, up front, in advance of the sale of assets.

These were demanding conditions and they have not been fully met. For example decisions reached in South-East Thames in relation to Guy's/Thomas' could lead to a separation of basic and clinical research from those delivering the clinical service. Major concerns also remain in relation to Hammersmith Hospital, the largest single focus of MRC investment in London. RPMS/Hammersmith has a long established international reputation for research excellence. RPMS is the only UK multi-disciplinary postgraduate education and research centre with access to a broad case mix of patients and the only institution where hospital and academic interests are so closely integrated that the Heads of Department at RPMS are also Chiefs of Service at the hospital. Because of this Hammersmith Hospital was selected as the focus of the MRC's Clinical Research Initiative, and the Council has recently establised its Clinical Sciences Centre there. The MRC therefore has a particular interest in developments following the creation of a new NHS Trust covering both Hammersmith and Charing Cross Hospitals and has already commented that for the new Trust to be effective:

- there must be full provision from the outset for the necessary capital sums for facilities on both sides;
- the hospital must be research-led and integrate the planning of service, education and research needs.

The MRC will be playing its part in trying to achieve these objectives in the planning of the new institution. The problems that have arisen in London illustrate the extent of the tension that exists between the need for a degree of central planning in the interests of the long-term health of UK clinical research and the principle of allowing purchasers maximum freedom in determining service provision. Similar issues arise in relation to the implementation of the recommendations of the Department of Health's specialty reviews on the disposition of certain specialist centres in the capital; we remain unclear as to how these recommendations will in practice feed through into the planning of hospital services.

The lengthy process of deciding the future of individual hospitals has inevitably led to uncertainty and there is evidence to suggest that those taking decisions about their careers have not seen London medical schools as providing the secure and productive environments in which to establish their research.

The merger of undergraduate medical schools with multifaculty colleges has strong support from the MRC since it will integrate biological and physical sciences with clinical research and service.

Annex

Submission to the NHS Research Task Force from the Medical Research Council

1. The Medical Research Council

The mission of the MRC, as set out in the Government White Paper "Realising our potential", is "to promote and support, by any means, high-quality basic, strategic and applied research . . . in the biomedical and other sciences, with the aim of maintaining and improving human health." The MRC's programme of research therefore encompasses human biology at all levels and ranges from studies of molecules, cells, organs and systems to research on individuals and populations in relation to the environment in which they live and work. The Council has a special concern and responsibility in relation to the national capability for medical research (both basic and applied) and for capitalising on scientific opportunities.

As the main publicly funded body for medical research the MRC also has a special responsibility, reinforced by the White Paper, to work closely with Government departments especially the Health Departments and with the NHS and to take account of their needs. Formalised in the Concordat (January 1992), the MRC and the Health Departments have agreed partnership arrangements for promoting, funding and managing medical research in the UK. Provision is made for the Health Departments to have an input into the development and determination of the MRC's research strategies and funding decisions. In recognition of the fact that the clinical work of the MRC would not be possible without NHS patients, the Concordat states that "it is the policy of the Health Departments to ensure that, provided that adequate notice is given to the NHS, the funding of the NHS and the policies of purchasers and provider units continue to make provision for the necessary service support for that research supported from MRC funds." This records a commitment which has existed since the 1950s.

2. Most important NHS contributions to MRC activities

Staff:

- extra nursing time
- extra medical time
- paramedic support eg physiotherapy, occupational therapy, social work, counselling

Funds/facilities

- extra in-patient days
- extra out-patient visits
- extra drugs/treatment
- additional investigations/pathology/scans
- additional care services eg counselling
- costs of post-mortems
- data management and patient records
- charges for cross-referrals
- library costs

Patients

- tertiary referrals to specialist centres
- adequate supply of patients with common conditions

Infrastructure

- some accommodation costs (including in general practice)

In addition to its research contributions, the MRC makes a direct contribution to NHS service. Details are set out in *annex 1* attached (*not printed*).

3. STRENGTHS AND WEAKNESSES OF PRESENT ARRANGEMENTS FOR SECURING NHS SUPPORT

Strengths

Both SHA funding and SIFTR allocations have in practice taken the form of providing infrastructure support to major centres of medical education and research and this has facilitated the development of centres of international status.

Weaknesses

- The total sum available for SIFTR is derived from calculations of the differences in costs between teaching and non-teaching hospitals, not from any assessment of the actual service costs associated with teaching and research.
- SIFTR allocations to RHAs are proportional to the number of undergraduate medical and dental students in the Region. No account is taken of the levels of research activity and the distribution of research is very different from that of undergraduate teaching (see table at *annex 2* attached) (*not printed*).
- Because of the way SIFTR allocations are calculated and allocated, they are generally viewed by hospitals as a non-specific provider subsidy. They are therefore not available to serve as a special allocation targeted at meeting the excess service costs of research projects.
- Hospitals that do not engage in undergraduate teaching do not receive any funding to meet excess service costs of research (except in the few cases where their research income is in excess of £100K pa). Many of these district general hospitals however have traditionally been involved in clinical trials—and this is in the best interests of the NHS because it helps in the dissemination of good practice throughout the service. However in the absence of any special funding to help meet the excess service associated with participation in trials there is growing evidence (which we can document) of unwillingness on the part of many hospitals to play their part in trials and HTA.
- There is no provision for the support of research in general practice. There is growing pressure on GPs to charge for certain costs involved in undertaking research since they are being encouraged to use their premises and resources for income-generating activities. Research does not generate income in the same way and there is again growing evidence that GPs are as a consequence less willing to participate in research.
- A further disincentive for fund-holding GPs is that the initial screening of patients necessary for determining whether they should participate in a particular study may in itself expose health problems that would not otherwise have been identified and so place additional demands on their budgets. (Again we have clear evidence that this is discouraging GPs from participating in research.)
- Multi-centre studies involve MRC officers in negotiating with up to 17 health authorities over the provision of excess service costs. This often delays the research and is an ineffective use of MRC and NHS resources.
- The complexity and uncertainties associated with the present arrangements serve as a disincentive to busy clinicians/academics undertaking clinical research and/or participating in multi-centre trials.

4. THREATS AND OPPORTUNITIES FORESEEN OVER THE NEXT FIVE TO TEN YEARS

(a) *The evolution of the NHS market for patient care*

Purchasers are required to make judgements on the qualitiy and cost of clinical services and hence on their value for money. The development of the purchasing function therefore offers exciting opportunities to widen the interest in and commitment to R&D within the NHS so that well-informed judgements in purchasing are made and the process of disseminating information about best clinical practice throughout the service is encouraged. A drive for the "best" and most cost-effective therapy should indeed serve as a stimulus to R&D activity.

On the other hand it is difficult for purchasers to take on board the needs of research where the benefits are often medium or long-term and are for the NHS as a whole rather than for individual patients or the patients in a particular locality. In an NHS market where there are no special arrangements to protect teaching and research there will be threats both to the support for particular research programmes and for the long-term survival of high-quality academic institutions. Scientific developments are increasingly pointing to the importance of bringing together biological and clinical scientists in a multi-disciplinary environment within a clinical setting to ensure that major advances in the biological sciences are implemented to the benefit of clinical practice. The patient needs of these special centres will not necessarily mesh with purchaser contracts. Special arrangements are therefore necessary to ensure that purchasers accept a responsibility for the longer-term health of the NHS by placing contracts in such a way as to ensure that there are adequate patient flows for research needs.

(b) *Changing NHS priorities for R&D in an NHS setting*

In research it is important to maintain flexibility to respond to new health needs and NHS priorities as they arise. On the other hand we need to maintain long-term investment in research which is paving the way for clinical benefits in 10-15 years; this involves a continuing commitment, subject to the quality of work being maintained, unaffected by changing research fashions.

The increasing emphasis on primary care presents exciting research opportunities and the MRC is expanding its commitments in this area.

5. KEY FEATURES WE WOULD WISH TO SEE IN THE FUTURE FRAMEWORK FOR NHS SUPPORT OF R&D

We would see the main features of any new system of service support as being:

- Separation of the funding of the service costs of research from that of the service costs of teaching.
- If the funds are allocated from the centre to the new NHSME Regional Offices to meet the service costs of research, then the broad allocations at this level could be determined on the basis of the distribution of income for peer-reviewed clinical research between the new Regions.
- Provisions for some form of infrastructure funding in recognition of the fact that there are additional costs involved in being a major research hospital which are not directly attributable to specific research programmes—this would be analogous to the HEFC component of university research funding. Those in receipt of infrastructure funding would accept certain obligations to provide service suport for peer-reviewed research carried out in their institution eg to respond in a flexible way to the service needs of basic clinical studies; in such cases the service costs can be difficult to calculate accurately in advance and so progress might be hindered through a total dependence on project-related funding, as described below.
- Provision of project related funding to meet the specific excess service costs associated with particular research projects, as set out in the response to Question 2 above. The aim should be to ensure effective targeting and meet the need to account for how the funds are used without establishing such detailed costing procedures that there is a significant increase in hospital administrative costs.
- Given the current problems we have encountered with a system whereby SIFTR is in effect a provider subsidy we would see the balance between infrastructure and project-related funding as being weighted in favour of the project-related component.
- The provision of project-related funding needs to be such as to provide an *incentive* to hospitals (particularly DGHs which will not have infrastructure funding) to take part in clinical trials and HTA.
- The project related funding also needs to cover the service costs of research in primary care (whether this is research on general practice per se or research on health topics best carried out in a primary care environment). Given that in some cases relatively modest sums of money have to be allocated to a large number of general practices it might well be more efficient in relation to MRC funded work to channel funding through the MRC for the studies conducted.
- Recognition of the particular position and responsibilities of the MRC as set out in answer to Question 1 above. Health Department representatives are involved at each stage of the MRC's strategy development and funding processes—through membership of the Research Boards, Strategy Committee and Council. Assessment and evaluation criteria include applicability and exploitability (as well as scientific quality) and more specifically relevance to Health Department and NHS priorities. Using these criteria the claims of, say, an application for a basic clinical research project are weighed up against those of, say, a project in Health Services Research. Procedures therefore exist for weighing up costs against potential benefits, whether long or short term. In relation to MRC-funded research, decisions on project-related NHS service support would most efficiently be made at the same time and by the same bodies, so that account was taken of the total commitment of public funds for a particular project or programme. This would suggest that a budget for meeting the project-related service costs of MRC-funded research should be determined in advance on an annual basis through the consultation procedures laid down in the Concordat.
- In considering whether R&D funded by other bodies should have access to NHS funds for service support account should be taken of whether that research has been subject to a peer review process which has the following components:
    - applications open to all those working in a particular research field in a region;
    - assessment by scientific peers which excludes those with a direct interest in the outcome.

— The system should be transparent ie details of all funding for service support whether infrastructure or project-based should be publicly available.

MRC Funded Research where there have been difficulties with NHS Service Support

1. MULTICENTRE TRIAL OF THE USE OF ANTIBIOTICS IN PREVENTING PRETERM LABOUR—ORACLE

Dr W O Tarnow-Mordi
Department of Child Health
Ninewells Hospital Medical School
Dundee

Antibiotics are being used increasingly in obstetrics to prevent preterm labour, with no definitive evidence of their effectiveness or cost effectiveness. ORACLE is a multicentre randomised controlled trial to evaluate whether the use of antibiotics in women at high risk prevents preterm labour. The results of the study have major implications for obstetric care policy and, through the prevention of preterm births, could reduce substantially neonatal intensive care needs, prenatal morbidity and mortality and the longer term healthcare needs consequent upon premature births. As such the trial could lead to significant savings for the NHS.

The trial is being conducted in hospitals around the country. The MRC is meeting the research costs in full, but the costs of the antibiotics and the placebo were considered to be the excess service costs of the research. The Regional Health Authority R&D Directors were contacted and provided with an approximate estimate of the costs of the drugs incurred for hospitals within their region, and most of them have agreed to provide the support to enable the trial to proceed.

2. COLORECTAL CANCER SCREENING

Professor Hardcastle

This is one of the instances of general practitioners proving unwilling to take on the financial responsibility for investigations that are necessitated as a result of a positive screening test (the cost of colonoscopy, the next stage of the investigation if a faecal occult blood test is positive, is £383). The work is aimed at measuring the extent to which the mortality from colorectal cancer may be reduced by screening to detect early invasive cancer, and the extent to which the incidence of invasive cancer may be reduced by detection and removal of pre malignant adenomas.

3. RANDOMISED CONTROLLED TRIAL OF LITHOTRIPSY FOR SMALL ASYMPTOMATIC RENAL CALCULI AGAINST NO TREATMENT

Dr R Feneley et al
Lithotriptor Department,
Southmead Hospital,
Westbury-on-Trym,
Bristol

Since the introduction of the lithotriptor in 1982 there has been a substantial increase in the number of patients referred for the treatment of renal stones. This trial was established to assess lithotripsy for patients with small asymptomatic renal stones and to assess in the longer term whether patients treated by extracorpeal short wave lithotripsy (ESWL) developed a higher incidence of hypertension.

The project is hospital and community based at two centres—Manchester and Bristol. The project was supported by the Consultant Urologists in the South West and North West regions who had agreed to refer two to three patients each, per annum.

GP fundholders and hospitals in S Western region are no longer prepared to transfer patients to the lithotriptor unit due to the costs of travel and treatment (£300 to £500), preferring, instead, to use the cheaper mobile lithotriptor which visits each hospital. It was necessary to ensure that the cost of treatment to the referring district and the travel costs for the patients were fully covered by the research grant. Other additional service costs relate to the cost of equipment and its maintenance, procedure and treatment costs including nursing and in- and out-patient attendance. It had been anticipated that 200-300 patients per annum would be recruited within the two regions and that recruitment would continue for two years. The recruitment rate has been reduced because participating clinicians have difficulty funding the necessary lithotripsies and after 18 months only 50 patients have been recruited in the two centres—as each consultant was restricted as to the total number of lithotripsies they could carry out, they had to give priority to symptomatic cases—This has now been resolved by the two Regional Directors of R&D agreeing to fund the extra costs in this instance.

4. MULTICENTRE ASSESSMENT AND MANAGEMENT OF ELDERLY PEOPLE IN THE COMMUNITY

Dr A Fletcher, Dr D Jones

This trial seeks to compare different forms of assessing and managing elderly people within the community. Research funding for the trial was secured under the aegis of the Health Services and Public Health Research

Board (HSRB) with an HD contribution, and should provide information that is highly relevant to the NHS implementation of the GP contract obligation to offer an annual screening to all patients aged over 75. It will evaluate the benefits of alternative methods of screening, and the subsequent management of patients by GPs as compared with specialist geriatric teams. Some of the excess and routine service costs of this study—those relating to the costs of the initial screening—(almost £670,000) are, exceptionally, being borne by the MRC which should ensure that the screening procedures are carried out by research nurses in a standard format. However there are also excess service costs of this research in the form of additional blood and urine tests (totalling about £230,000) and additional costs relating to the subsequent care of patitents. Discussions and correspondence with the Department for over six months have failed to resolve the problem. This trial raises particular difficulties because of (1) the lack of provision of service support for research in general practice; (2) the difficulty in estimating the scale of the service costs in view of the lack of reliable data on the prevalence of morbidity amongst elderly people, a deficiency which the trial will address.

5. AIDS Delta trial

In relation to the Council's programme of clinical trails of treatment for patients with HIV infection the preliminary data published from the first trial, Concorde, are likely to have significant impact on treatment of HIV disease and therefore reduce NHS costs substantially. The preliminary data showed that there was no benefit of early treatment with AZT in asymptomatic patients as compared with deferment until clinical symptoms appeared. A further large trial is now underway to compare treatment with a combination of two anti viral agents (which may delay or prevent the development of drug resistance) with standard monotherapy, which so far has been of limited benefit. Discussions with the Department over the provision of the support for the Delta trial from 1 April 1994 onwards, have been in progress over some months. A letter to participating centres has been sent by the Office asking them to contact RDRDs and Regional Directors of Finance to notify of any service support requirements for the next financial year. The Office and the HIV Clinical Trials Centres have provided participating centres with an estimate of these excess service costs.

6. Prospective Cohort Study: Determining the appropriateness of surgery for stress incontinence in women

Nick Black
London School of Hygiene & Tropical Medicine

This prospective cohort survey requires, for statistical purposes, that 500 patients undergoing surgery for stress incontinence are recruited. Based on analyses of data gathered in a 1 year pilot study (1991-1992), it seemed feasible to obtain such a sample in 12 months using 20-30 surgeons to recruit patients. This study commenced recruitment in 1993 and surgical admissions have not been as high as previously estimated. As of November, only 300 patients had been recruited, despite an increase (from June) in surgeons to 62. Monthly follow up visits to participating hospitals suggests that this drop in numbers is not a systematic failure on the researchers' part to recruit eligible patients, but rather the changing patterns of hospital admissions have resulted in several surgeons being asked to restrict admissions towards the close of the 1992/3 financial year due to lack of funds. The patients in this trial are accorded lower priority as stress incontinence is not a life threatening disorder. This situation has resulted in the need to extend the research project, at a significant cost to Council, to enable the project to reach a successful conclusion. Similar reports are emerging as some departments have gone over budget or completed their quota of contracted cases for the year which ends in March 1994.

7. Thrombosis Prevention Trial

Professor T Mead
Epidemiology and Medical Care Unit
London

The randomised controlled trial aims to evaluate the effects of warfarin and aspirin, singly or combined, in men at high risk of cardiovascular events. The trial is being conducted through the Council's General Practice Research Framework. As a part of the treatment protocol, all patients undergo analysis and in some cases haematuria has been detected which has led to the need for further clinical investigation to clarify the cause of the haematuria. GPs, in particular fund holders, have been unwilling to meet the costs of the additional tests and, exceptionally, the Unit has supplemented the GPs' budgets to meet these excess service costs.

Examination of witnesses

SIR DAI REES, Secretary, DR DAVID EVERED, Second Secretary, and DR JOAN BOX, Health Departments and NHS Relationships Officer of the Medical Research Council, were called in and examined.

Chairman

57. Good morning, Sir Dai, Dr Evered and Dr Box. Thank you so much for coming to see us and thank you, too, for your memorandum, which we have all read with interest. Having read your memorandum, we, I think, have a very clear picture of your standing in relation to the support of research in the NHS but it could be that you would wish to make an opening statement this morning before we go on to the questions, so we would be happy to hear that.

(*Dr David Evered*) Thank you very much, my Lord Chairman. Yes, we would like to take the opportunity which you have just offered us to make an opening statement and perhaps I might respond, first of all, to one of the comments in your introduction. We have, of course, worked through the 17 additional questions which were posed to us and we plan to provide you with a written response to those, if we may, amended in the light of some of the additional questions which I am sure you will pose to us during the course of this discussion. If I might make one or two rather general, but what we regard as key points first. The MRC, as we have made clear, has a national responsibility for promoting research which has as its objective the improvement of health. To achieve this, we work, of course, in close partnership with our principal users, both the Health Departments and the National Health Service, and that responsibility is to carry out research which will underpin and inform the development of public health policy and also to carry out research which will lead to the development and improvement of the National Health Service. As you well know, those partnership arrangements are described in the Concordat, which provides for inputs from each party to the strategic development of the other and which also lays responsibilities on both parties. In reaching judgments on what we should support and in what areas initiatives should be developed, we operate a two-stage process. One is rigorous peer review, which, of course, is the quality assurance component of the work that the Council carries out, and the other is rigorous merit review, which assesses the applicability and importance of the research to the users. The advantage of these arrangements is that we can act as an independent but responsive agent and be the guarantor of research of the highest quality. There are two, I think, key needs of the MRC. There are many others but there are two which we regard as essential to our operation of the interface with the health departments and health service. The first is clearly defined and robust mechanisms for the provision of services support, and secondly, we need effective mechanisms on the part of the health departments and the National Health Service to ensure that the needs and arrangements for R&D are considered at national and regional level rather than at local level. Almost all clinical and health service research will be of benefit to the health departments and the NHS as a whole and it is in general far beyond the range of local resources to identify those research needs, to fund the research and, in many instances, thinking of multi-centre studies, to prosecute significant studies. If I can make one final point, I think we should not forget—and certainly we do not forget—that there is a further major public sector partner involved in this enterprise and that is the universities. They are increasingly starting to address their White Paper responsibilities towards their users, and we are increasingly working in close partnership with them, partly through targeted initiatives and also in a number of other ways to meet the needs of our common users. That is all I would wish to say.

58. You, of course, defend the Concordat. It has been suggested to us now that the Association of Medical Research Charities and the bodies represented therein are producing more funding even than the MRC for research in the NHS and that they might achieve a similar Concordat. I would like to know what you think about that, and would you expect the MRC to be exempt from the procedures proposed in the Culyer report, which suggest that before anyone applies for a project grant the clinical facilities required to undertake the research should be approved by the host institution, either the university or, in this case, NHS hospitals, or the general area in the NHS where the work would be done?

(*Dr David Evered*) If I can take the last part of that first, the answer to that must be no. There is no reason that we can envisage that the MRC should be exempt from the mechanisms which are set up following the Culyer review. But perhaps I might link to that answer the response to another part of the written questions, which was, does the MRC have excellent and relevant clinical research which might be greater than that which the NHS is able to support? There is, of course, no very clear-cut answer to that question. We have no reason to believe that the MRC will wish to support a greater volume of clinical research than the NHS should be in a position to support. In support of that contention I would point to the fact that this has not created problems in the past when the old uncosted arrangements were in place. But, of course, I cannot assert that with absolute certainty simply because the old arrangements were wholly uncosted and nobody knows clearly the true cost of provision of service support, although certain studies are now beginning to give us some insight into that. You raised the question of concordats with other bodies. In principle, I think the answer to that has to be no. There is no reason why there should not be concordats with other agencies but I think it must be remembered that if such arrangements were to be set up they ought to be set up along parallel lines to those which pertain to the MRC, where we each have duties and obligations and the opportunity to make an input into the planning and strategic development of the other bodies.

[Chairman *contd.*]

59. Concern has been expressed in recent years over the volume of applications dealing with clinical research which the MRC has received in comparison with those concerned with more basic or fundamental research. Has there been a significant change of late in the proportion of such grant applications?

(*Dr David Evered*) No, the answer to that is that there has not. Taking a long, or longish, view, there has really been very little change in the overall volume of clinical research which has been supported by the Council going back over the last 15 or 20 years. The ways in which we have supported clinical research have certainly changed during that period of time and, as you and your colleagues know, we have been taking, and, indeed, are continuing to take, steps to develop and strengthen the clinical research base in the United Kingdom at present.

60. There has been some concern expressed in the university world in particular, which may or may not be justified, that the transfer of the dual support infrastructure funds from the higher education funding councils to the research councils, which had been intended to introduce a mechanism whereby the overhead support would come back to the researchers in the departments through research council grants, may not have worked as smoothly as was originally intended. What is your view about that?

(*Dr David Evered*) I would not wish to suggest that the dual support transfer has been trouble-free; it clearly has not. I think, though, it is worth making two points. The extent to which there have been problems and tensions within certain academic institutions does, to a significant extent, reflect the management structures within those institutions. The changes have been achieved really remarkably smoothly in some institutions, particularly those which have a highly devolved system of budgeting, the highly "Jarretised" universities. I think it is also fair to say that the problems perhaps have been rather less in the biomedical sciences than they have been in some other areas and there are a number of technical reasons why one might have anticipated that that would be the case.

61. The Office of Science and Technology gave us an assurance some time ago that that transfer related solely to the infrastructure funds required for the support of research council research and not for the support of research funded, for instance, by charities and other bodies. Would it be your view that a similar transfer should be achieved in relation to the "R" component of SIFTR in NHS hospitals, if that can be properly applied?

(*Dr David Evered*) Yes, I think there is a logic to that and it should, and ought to, improve the targeting of funds. We did discuss this at some length before I presented evidence to the Culyer task force. We felt, however, that we should not pursue this at this stage since we were concerned that this might place a very difficult and substantial administrative burden on the Council. However, there is perhaps one exception to that which is worth thinking further about and that is the provision of service support for research which is carried out within general practice, because inevitably this involves research which is carried out in rather small quanta of activity across a substantial number of practices. So I think that may be an exception, but in general I think the answer should be no, at least for the present.

62. Thank you, because I know there is concern in the charities world about the prospect of their being required to pay overheads in the future and at the moment they are not being requested by most institutions to do so. May we then ask you briefly whether you see a system of support by the MRC or other research funders of research beds, as happens in certain other countries, as, for instance, the United States?

(*Dr David Evered*) My answer to that, my Lord Chairman, would be no. We are strongly supportive of the Culyer proposal that there should be a service support funding stream which should maintain the core facilities for research in research-active institutions. I do, however, take the view very strongly that R&D work should be integral to the operation of the National Health Service. Indeed, this was the thrust of your Lordships' earlier report and was very much the thinking behind Professor Peckham's appointment. What is key is access to facilities, and I also take the view that we should perhaps not get ourselves too hung up on the use of beds as a measure of hospital activity, particularly in an age where we are progressively shifting the balance away from in-patient towards more day-based and primary and community-based care. The clinical centre at the NIH, of course, is in the process of reducing the number of beds which it has very substantially at the present time.

Lord Butterfield

63. I am very intrigued to learn about the Clinical Research Initiative. I am sitting beside Lord Nelson, who was the Chairman of the last Committee that reported, and we were, of course, at that time concerned that the MRC might strengthen the contribution of clinicians to your work and we were anxious that you were getting more and more clinicians interested in working with the charities rather than being interested in working along with you. Would you be kind and put something into the record about your Clinical Research Initiative?

(*Dr David Evered*) The Clinical Research Initiative grew out of a widespread concern that the clinical research base was not as strong as it had traditionally been in this country, and the Council shared that concern. Indeed, your adviser was a member of the Council at the time these plans were originally being formulated. At the same time as we were considering how to address that concern, of course we had an MRC problem and that was our Clinical Research Centre. The Clinical Research Initiative was an initiative which essentially had one major objective and that was to improve the interface between the basic biological sciences and clinical science and particularly to translate the developments in what is known as the new biology into the clinical environment so that clinical problems could be addressed using those new techniques. The Initiative has a number of components. It has a major new centre which has just been opened at the Hammersmith Hospital, which has a number of

[Lord Butterfield *contd.*]

scientific themes but the most important and central one is related to gene therapy. There have also been a number of other clinical sciences centres which have been set up in other cities—Birmingham, Cardiff, Nottingham, Newcastle, Edinburgh and Glasgow—and we are considering the possibility of a further one in Southampton at the present time. These are all focused in different areas, some in vascular disease, some in neuro-psychiatric disease, one in diabetes, one in bacterial infections and so on. We can easily provide details. The other key component of the Clinical Research Initiative was to increase the opportunities for research training and career development and that we have done very substantially. In the five years prior to your Lordships' last report we were supporting about 22 or 23 clinical training fellows each year; last year we made awards to 60, so there has been a very substantial increase. On top of that we have, of course, introduced the new so-called clinician scientist fellowship scheme and we have increased the numbers from the original three or four per annum in 1988 when we first ran the scheme up to ten or eleven per annum, which is the current rate. So we are taking steps to build up capacity by focusing on training bright young people within the system. At the same time we are also conscious of some of the difficulties which are faced by clinicians at all levels but perhaps particularly at senior level at the present time and are beginning to look at new ways in which we might give highly talented individuals a longer-term career in research. We are relaunching our MRC professorship and readership schemes and are in discussion with a number of universities at the present time about possible candidates. So although the high-profile component of the Initiative is focused on the major investments in specific institutions, the building up of capacity by training young people—and this is not only taking place in those institutions—is an equally important component of the Initiative. We are now thinking how to build on that and develop a Phase 2.

(*Sir Dai Rees*) I wonder if I may add, as a non-clinician, that although we do recognise the very special problems and difficulties that the clinical community within MRC has in doing research, for the reasons which have led to your undertaking this study, but we try very hard *not* to set up a situation which causes clinical researchers to become a separate and isolated community within MRC. The whole drive of the Clinical Research Initiative was to set up activities which were supported by relevant activities in basic science. We are at a stage in medical research where there are a number of important new areas of science to develop for application to medicine, such as genetics, such as new and more fundamental approaches to neuroscience, such as developmental biology and its possible applications. In exploring all these new areas of science, many of which are of interest to industry, we are encouraged by the White Paper to look in that direction, too. In all of these we put a lot of energy into attempting to build and foster the clinical dimension so that in our Initiative on genetic approach to human health, for example, you will find very explicit clinical activities drawing in and interacting with basic science; in our neurosciences approach to human health likewise. In our AIDS initiative also, which goes all the way from fundamental immunology and virology to epidemiological and clinical studies, and in the new initiative that we hope to be able to support, on the study of variations in health, with all the sociological and nutrition and other aspects. The way in which we are trying to foster clinical research is by integration of these major advances into future clinical activities.

Chairman

64. We will come back to Lord Butterfield in a moment but I remember he and I were on the MRC together. It is 16 years since we both came off, I think, and at that time there were posts which were established for clinical research fellowships at a very senior stage, rather comparable in some respects to the Royal Society's research professorships. One way, of course, in which it was handled was by appointing certain people to the external staff, but I think the clinical research fellowships were intended to be short-term, perhaps for someone of high research capability to move out of a clinical department with a view that they could take leave of absence to do research and then go back again. Is that the present policy with respect to these clinical awards? How many do you envisage per annum and what would be the duration of their tenure?

(*Dr David Evered*) You are focusing on the most senior awards?

65. Yes?

(*Dr David Evered*) These will be on a five-year rolling basis, so that we do envisage their being long-term, and clearly if we get our selection processes right they will be long-term.

66. But they will be for individuals to work in centres of excellence which will not, in the beginning, be defined? It will be for the individuals to apply for these?

(*Dr David Evered*) Yes, and the qualifying criterion will be the ability to win a programme grant in competition.

67. How many a year do you think you are going to be able to support?

(*Dr David Evered*) We have not set a quota for these. We are currently exploring the possibilities. By their nature there is only going to be a limited number of new creations each year but I do not think I wish to offer a hostage to fortune about numbers at present because clearly quality is the crucial qualifying criterion.

Lord Butterfield

68. I can see that there is going to be an interesting cash-flow type of problem for you down the line where you are training people and they are going back into the hurly-burly of medicine generally and they will be wondering, I suppose, to some extent, what are the chances that money will be coming from the Council or other sources to keep me going as a clinical investigator, or shall I get back into the river and take care of the increasing demands for high-quality care for people, and that really is what lies behind our question. How many long-term honorary NHS consultant contracts are you concerned with in

[Lord Butterfield *contd.*]

the Council, has the number changed over time and what does this tell us about the state of clinical research?

(*Dr David Evered*) The answer to the first question in numerical terms is that the number has gone down over the course of the last ten or twelve years by about 30 to 32 per cent. Much of that, of course, relates to the closure of the Clinical Research Centre, which has made a uniquely large contribution to that figure. I would like to add to that, however, that it is a key component of Council policy that we build up our research activities within the university system. That is true across the board and it is the Council's policy now that all units should not only be located on university campuses but integrated with their host departments and institutions, so that we achieve the synergic relationships which we all agree are essential. So we have been focusing our attention on building up support within the university sector and that has also contributed to the decline of MRC directly supported staff who have consultant contracts. Having said that, I acknowledge the points which you made in the introduction to your question, that we are now building up a substantial cadre of trainees and clinician scientists, not all of whom, of course, will make the grade as principal investigators. But if our selection processes are as good as we believe they should be then a substantial number will, and that is something we do need to consider not only in isolation but also in discussion with the charities and with the universities. We are not only training principal investigators for future Council appointments but also for senior appointments elsewhere within the system. Part of our approach to addressing this has been to relaunch our MRC professorship and readership scheme, but, as I said a moment ago, we do not and should not work in isolation from other agencies and I think we do need to have better mechanisms in place both for career management as people are in training and for planning future opportunities at a senior level.

(*Sir Dai Rees*) But we do recognise that there has been a gap, that when people have gone through these clinical research fellowships, what then? I think we need a more complete ladder than we have operated in the past. Clinical professorships have existed but their numbers have been rather smaller and I think they have to be seen as a real possibility for research workers who demonstrate real talent, and a readership option which we have not really used in the recent past as a stepping-stone to professorships must also be seen and we need role models in those positions and so on. So, as David has been saying, we cannot solve the national problem but I think we can create an MRC microcosm which shows some good content.

69. I was very fortunate in getting to Guys to work with Tom Lewis, who established the first clinical research unit at Guys, and he made it a very strong point during the initiation into this unit that if you were not of the cast of mind or the "celibacy", he used to say, that was necessary to be a really good research worker "like me", he would say, "then you will have to have plans to get back into clinical work and you must take the membership so that you can do that," and he was quite active in ensuring that there was an alternative ladder on to which I could climb if I wanted or needed to and that it would be no disgrace to get on to that alternative ladder. I might have failed to be a first-class cricketer but I could play good county cricket which would be good for the game. I just think that sometimes in career management we do not make it clear enough to people that you can do an awful lot of good in medicine if you have good research practice to apply that research to what you do.

(*Sir Dai Rees*) Yes. There is equally another point. I accept entirely what you say but it is difficult for people to continue as clinicians and researchers and decide that their first love is research but then become basic researchers who happen to have clinical degrees or qualifications doing things which basic scientists can do. That is not really helping us from our point of view. Of course, if they want to do that, that is fine, if they are driven by the system in that direction rather than staying in this crucial interface which we need to be healthy for the delivery of our product.

Chairman] That is a very important point, just as it is very important, following on from what Lord Butterfield said, that there must be a proper and compassionate mechanism for terminating such appointments in the case of those who run out of research steam, which happens even with the very brightest of people sometimes.

Baroness Perry of Southwark

70. You talked about integrating research into university departments and your vision of that. That presumably is not always medical schools? It could be university departments.

(*Dr David Evered*) That is absolutely correct.

71. There is a different problem there, is there not, for the researcher who might wish to be long-term and your funding is short-term? They do not have the alternative ladder quite so conveniently placed beneath their feet as the clinician. They have the alternative career of going back into the hurly-burly of clinical practice. Do you have any thoughts on the problems of that, and remembering the other enquiries at that time which tended to be on that subject?

(*Sir Dai Rees*) Absolutely. This is a central issue within the White Paper, the scandal of this great army of short-term contract research workers who are having the benefit of no career development or career planning or counselling in many cases. We are addressing that. We have set up a series of consultations with the vice chancellors of those universities which receive most of our funding, including Cambridge, and we are discussing schemes whereby we do more for the long-term infrastructure and health of the research in certain areas of those universities in return for a shared obligation for career development, which might include even work experience and so on, and particularly career counselling. So we are aware of it and it is a problem we can solve within our institutes and units, of course, where people are on our pay-roll and I think we do a reasonable job, but on short-term contract research, it is something which we cannot do ourselves and we must do it together with the universities. We have been talking to the CVCP

[Baroness Perry of Southwark *contd.*]

about this as well and I understand you are seeing them next week.

Chairman

72. Are you proposing to invoice the NHS for clinical services? Is there any prospect that this might arise?

(*Dr David Evered*) The answer to that is no.

73. I hoped it would be a rhetorical question.

(*Dr David Evered*) I think there is one minor issue and that is whether it is entirely proper for MRC to meet extra duty payments for its junior clinicians which are purely for service purposes. It is in a sense a side issue, but the answer to your direct question is no.

74. I think it would not be proper for this particular Sub-Committee to get into that particular problem.

(*Dr David Evered*) I understand that.

75. What about the administrative burden of Culyer? Do you think it is likely to cause greater problems?

(*Dr David Evered*) I think I would have to say that ensuring that proper service support is provided for MRC funded research is already a very substantial burden on my colleagues. Very clearly, while we all subscribe to the principles which are being articulated by Culyer, the potential is there for setting up an enormously bureaucratic system. Now my colleagues are working with officials in Professor Peckham's division of the Department of Health to try to ensure it is implemented in a way which is as simple, straightforward and transparent as possible. If we can achieve that I would suggest that the administrative burden might well decline from that which pertains at the present time when we are having to resolve a number of problems relating to service support on a case-by-case basis.

76. We have some evidence based on the experience of a single unit suggesting a danger that with the recent reform of the National Health Service, because of cost, tertiary referrals to centres of excellence may have been falling off. It was pointed out to us, for example, by Professor Richard Hughes of Guys Hospital, who works in neurology, that he is involved in a series of international collaborative trials of treatment of Guillain-Barré syndrome and there has been a very striking reduction in the number of referrals of such cases from other hospital districts on cost grounds. Culyer does address this issue but we would like to know what the MRC feels about the problem?

(*Dr David Evered*) We regard this as a crucially important area. Indeed, when making a presentation to the task force I did make a considerable point of this. I think there are two components to this. The first is the issue of extra-contractual referrals for rare or relatively uncommon conditions such as Guillain-Barré syndrome, which we do know is beginning to cause problems around the United Kingdom because the contracting cost of ECRs is not inconsiderable and there is often a great reluctance on the part of local purchasers to meet that cost. I think there is another problem in relation to tertiary referrals and that relates to major clinics for common disorders. Clinics for diabetes, for hypertension or asthma, a lot of common disorders, do exist within teaching institutions. They are invaluable resources, both for educational and research purposes. All these conditions, of course, can be treated in local provider units and many can be treated by general practitioners, but there is a risk that some of these major clinics, which not only set the standards for clinical practice but also provide the basis for much essential research, could be lost if the need for them is not clearly understood and provision is not made for these within the Culyer funding proposals. I think there is another issue which also needs to be considered because to whatever extent the playing field may be levelled, there has to be a recognition on the part of purchasers when placing contracts that the longer-term interests of the service demand that such clinics should be retained. At present purchasers are under no obligation to use those clinics even though they may be no more expensive than those clinics in their local provider units. So I think there is a key issue there. We are aware that there are problems of this nature beginning to occur and I think Sir Keith Peters may have told you that the Joint Medical Advisory Committee of the Funding Councils is currently conducting a monitoring exercise looking at the university/NHS interface. We are about halfway through that at the present time but a number of institutions have flagged this up as an issue.

77. Would you care to help us by suggesting a mechanism that might be introduced to protect tertiary referrals and the preservation of the specialist clinics you referred to?

(*Dr David Evered*) I think there are two elements there. One is to ensure that the contract prices which are set by the teaching research-active provider units are no higher than those of their non-academic competitors and ideally one needs to think a little bit about incentives in terms of some sort of incentive pricing of those contracts. But I think there is a real issue which does need to be addressed at a purchaser level to ensure that while properly their major concerns are about achieving quality treatment in the most cost-effective way for those for whom they have responsibility, they do also have a longer-term responsibility for the development of the system for the future. I think that is a very difficult task to approach.

78. Is there not a risk that the implementation of the Culyer report could lead to a disaggregation of costs, including research costs, in the NHS and, therefore, to the demise of the "knock-for-knock" agreement?

(*Dr David Evered*) I think the answer to that is yes, but then a number of other changes within the system have already led to a very substantial unpicking of the knock-for-knock arrangement. It is almost inevitable if you move into a competitive contract-based system that that would occur.

79. From which it follows that if good quality research is to be maintained in the NHS hospitals, some kind of major subsidy, shall we say, from the "R" component must be allocated to the centres where that research is being done?

[Chairman *contd.*]

(*Dr David Evered*) Yes indeed, and there must be in place what does not currently exist with the SIFTR or ACT systems and that is a mechanism for tracking that resource through the system and for achieving proper accountability.

Lord Nelson of Stafford

80. When we looked at this before it came out very clearly that the role of the MRC, as explained by the MRC, was to deal with science-led research as compared with commercial-led research by the pharmaceutical companies and charitable objectives by the charities, and the missing link in the whole thing was the lack of need-led research from the National Health Service's research. Professor Peckham's appointment sprang out of our feeling that there was this need-led research and he has led that since and done a very good job, in my opinion, or that is the impression I get. Are we in danger of now proliferating this situation and creating an administrative nightmare? MRC strategies to meet the needs of the National Health Service and so on, seem to me to fall very much in the roles envisaged for Professor Peckham and his various research bodies set up within the National Health Service itself; added to which, you also say that you are engaging in an initiative in health services research. Very good. One of the things we said at the time was the lack of health services research and how important it was for a big organisation to have health services research, but it was envisaged at the time that it would be done within the National Health Service, not within the MRC with its science-led objective, and now we see it coming up as one of the objectives of the MRC. So I wonder if you can explain to me quite simply what has happened since four or five years ago?

(*Sir Dai Rees*) I do not think MRC has changed its position since I remember coming and giving evidence to your Committee, Lord Nelson. The issues are a little bit more complicated than you portray them. I think it is widely agreed that the British have a national disease which has led to the separation of science and application in all sorts of areas. The new developments in science policy, technology foresight, etc. are all designed to overcome that and bring science and application together. It would be, in our view, quite wrong to separate off health application stimulated by need into the NHS and away from the science push or science for science sake within the MRC. Fortunately we have never done that and I do not think we should. I think the division of labour between our research activities and the NHS research activities has to be decided much more interactively. That is the whole purpose of the Concordat and the nature of the relationships that have actually been set in place. For example, when Professor Peckham, the Director of Research and Development, has completed a study of, let us say, priorities for research in mental illness, there were clearly some of a direct practical nature for which he should take full responsibility for the NHS. But there are others which are really quite complicated and have to integrate backwards into leading edge science and therefore we should take them on. The distinction is more in terms of science content and the need for MRC's community to take responsibility even though they are stimulated by need rather than a simple division between what is stimulated by need and what is stimulated by curiosity.

81. Do you think there is a danger in fact of going too far and finishing up with an administrative nightmare of trying to co-ordinate one with the other?

(*Sir Dai Rees*) Well, the Concordat does involve a lot of talking. It is expensive in effort but in general it works very well. Just as in individual research, it is worth spending time to think out just what you are going to do and which experiments you are going to do and why, rather than charging into the laboratory with no planning.

82. I can imagine the health services research being done in the National Health Service and very much needs-led by the people who see the day to day problems, I cannot see that being an important role for the MRC if it still retains a science-led objective. I am all for it but is it the right place for it?

(*Dr David Evered*) I think there is a number of responses to that, Lord Nelson. The first is that we have been at some pains to identify what the MRC's role is in health services' research and indeed that definition is quoted in one of the supplementary questions, question 14. That definition of the Council's role in health services' research has been drawn up in discussion with the Health Departments which takes in some instances a rather different approach. Now there is some overlap between the two and there is a number of activities which one party or another will take forward by mutual agreement and we deveolp some through joint funding. It is much better, in our view, if there is some overlap at the interface rather than a crevasse or a chasm between us. What we crucially need in health services research are not simply answers to HSR questions. There is a considerable problem of a lack of high calibre researchers within the area so there is a training issue there which the MRC is well equipped to develop. There is also a major issue about the development of new and better methodologies for the conduct of health services research and that, of course, will be a major focus of our new health services research centre about which you have asked us and I can give you more details if you wish. In particular we can play to our own strengths by carrying out HSR studies which involve the generation and the testing of hypotheses and which will enable us to identify better the health needs of the community and test the effectiveness and efficiency of various interventions within the health field. So those are what we see as our roles. As Sir Dai Rees has said, there is a substantial amount of work at the interface but many of those who have the core skills of health services' research, recognising that it is a multi-disciplinary activity need to be brought together so that we can build multi-disciplinary teams.

(*Sir Dai Rees*) I think we should just add that we are going to have to look again at the amount of work that entails and try and simplify it in the light of experience of the Concordat. Also the recent cuts in staffing in the Department of Health mean that they

[Lord Nelson of Stafford *contd.*]

cannot even afford the resources that they have been putting into this joint process.

Earl of Selborne

83. What do you see as the role of the regions and how do you feel that they can contribute to the wider strategic research, bearing in mind clearly that there is a requirement to work within the format provided by the Central Research and Development Committee?

(*Dr David Evered*) We have invested a substantial amount of staff time in developing relationships with regions. We have had meetings with the regional directors of research and development. We have had a member of staff attending the research committees of the various regions as they have developed their strategy. We have set up in addition to the fellowships a joint small grant scheme which will enable regions to address research problems which are of a particular local importance. We do have all that in place but the structure of the system is changing very substantially and the old regions—the Regional Health Authorities—subject to legislation—will cease to exist in about 16 or 17 months or so from now and will be replaced by regional outposts of the NHS Executive. The appointments to the new regional research director posts are being made at the present time and clearly we will want to engage in this discussion further once those appointments are made. It has also not been made wholly clear what precisely should be the role of the regional outposts with respect to research and development. The assumption is that they will have a significant role but until that is defined of course we are a little limited at present in taking our dialogue forward. It is something to which we will accord a high priority when the arrangements are clarified.

84. We have had a number of research and development plans from the existing Regional Health Authorities which, of course, will not exist in a while. Clearly—and this is not necessarily a bad thing—there is a very different approach within some of the Regional Health Authorities to these issues. Would you wish to see them conform to a greater extent in future as a result of the co-ordinating activities of Professor Peckham and the Central Research and Development Committee or do you think there is value in each of the regions perhaps developing their own programme where their expertise lies?

(*Dr David Evered*) I opened my remarks by making the point that much research, both clinical and health services research, is of general rather than local applicability and that is correct. That is not to deny that there are some research questions which are, if not unique to a particular locality nonetheless have particular aspects to them within a single region and there are certain research questions which perhaps can be best addressed within one region taking the lead on behalf of all the others. I think there is a case for some diversity and heterogeneity within the system. I think probably one might even argue that the principle of subsidiarity which applies with respect to our membership in the European Union might also apply in this respect. My view is that the volume of work which is genuinely uniquely local is really rather small.

Lord Nelson of Stafford

85. Are we not reaching a stage where the MRC should cease to be a research council and become the research department of the National Health Service?

(*Sir Dai Rees*) No is the short answer. We are a mission orientated research council. We exist to do research which will improve human health which means it has to be delivered into places where research results are integrated into the provision of health in one way or another. The NHS is only one, albeit perhaps the most important, of those places. There is the pharmaceutical industry, there is the Department of the Environment with concerns about the environment and health, there is the policy side of the Department of Health where there are issues of the Health of the Nation White Paper. All of these raise questions which are outside of the NHS. These things are interactive so that, for example, doing work for the NHS often involves some interaction with, let us say, the pharmaceutical industry or joint ventures with another Government department and vice versa. With our independent status and freedom with responsibility against delivery of good results and good performance, I think we have a pretty good way of doing it.

Chairman

86. One other major partner of course is the universities too which are absolutely crucial in this setting.

(*Sir Dai Rees*) Absolutely.

87. I have often said, of course, that today's discovery in basic laboratory science brings tomorrow's practical development in patient care. It happens time and time again and we could quote my many examples. Can you give us any specific examples of ways in which the MRC or its scientists have contributed new technology or new approaches to health services research?

(*Dr David Evered*) I have to say, first of all, we are at an early stage.

88. Yes.

(*Dr David Evered*) I think if one goes back into history, of course, then the MRC can claim the parenthood of the randomised clinical trial which of course is one of the cornerstones of clinical research.

89. Right.

(*Dr David Evered*) In terms of the development of methodologies, within the new centre at Bristol there will be considerable focus on trying to identify, where appropriate, alternatives which go beyond the process of simply the conduct of the randomised clinical trials. There are also new methods to be developed for handling large data sets which exist in profusion within the health service but which are largely unexploited as a research resource. There are other examples but we are in an evolutionary stage.

90. Good.

(*Sir Dai Rees*) I am sure we can provide specific examples, for example, of surgical procedures and evaluation of day care versus hospitalisation of

[Chairman *contd.*]

elderly people for research treatments and so on. They are not tripping off my tongue at this very moment but we can send you them.

91. If you happen also to have any information about MRC work which has resulted in the development of new equipment and new techniques, high technology and so on, we would like to hear about that in due course?

(*Sir Dai Rees*) Of course, magnetic resonance imaging for example.

92. Yes.

(*Sir Dai Rees*) ...from which BTG is still deriving a substantial revenue as well as it being applied in the health care.

93. Of course going back a very, very long way the MRC and others used to get quite considerable royalties from cyclosporin.

(*Sir Dai Rees*) We will send you that information.

94. It would be helpful to know that. Following on from what Lord Nelson said, is there not a danger that these various changes with emphasis on strategy could lead to a top down approach with all its potential consequences?

(*Sir Dai Rees*) There is a danger but we realise it and hope we are avoiding it. In the good old days when you were a member of the Council, which was before my time...

95. Right!

(*Sir Dai Rees*) ...and concerning which, perhaps I can have on even rosier glasses than those who were around at the time. I imagine the Council as having been a sort of self-governing community of scientific and clinical researchers who developed their plans and allocated their resources to do what they thought the nation wanted or needed from research for the sake of health care. I think it is still important that as research becomes more expensive and as it becomes less and less possible to do everything that is conceivable, and therefore you have to actually focus—I think it is still important before you focus and are constrained by the availability of resources that the community should go through that kind of exercise. That is what we mean by strategy development. It means the community or university departments within the community actually taking a deliberate and conscious view about the direction in which they think they should be going with their research for the sake of delivering practical benefits.

Lord Nelson of Stafford

96. In other words the need?

(*Sir Dai Rees*) Sure, yes.

Chairman

97. At that time, of course, we did live through the era of the Rothschild Report and its implementation with the transfer of funds to the health departments which turned out to be something of a disaster. I think our only anxiety is that too much concentration on strategy would perhaps distort and influence future research.

(*Sir Dai Rees*) There is a lot of value in the purchaser/provider principle but it is capable of simplification to the point where you actually lose all sense of perspective and it becomes all about short term transactions.

Lord Butterfield

98. As to MRC contributions to health services research, we should not forget Donald Acheson's work on record linkage.

(*Sir Dai Rees*) Absolutely.

99. Do you get any increase in your resources as you take on new things? You are the custodians of Baconian philosophy in medicine, trying to find out by investigation what is good and what should be discarded. Now it seems to me when we said that we thought there was a case for more health services research we had no wish to create a situation where people doing health services research would be competing for a cake which was also wanted by the Laboratory for Molecular Biology, for example. Can I ask a very tough question: when the burdens of need are placed on you does the Treasury recognise this or do you need a few champions around who point out that in fact one of the reasons clinical research is becoming so difficult is that people know there is such a ring fence around the resources that it is going to be a terrific battle to get inside the ring fence and create a career which I think is much more difficult for the young men and women now than it was in my day. Lord Walton is a youngster but it was already getting tough in his time. It does seem to me there is a point in time when someone has to stand up and say: "You cannot go on loading the MRC with all these new approaches which are feedback from your own child, namely Peckham". You are servicing him, you see, whereas we wanted you to be able to say to Peckham, so-and-so is a good chap, we cannot use him but he would be very good in your health services research unit.

(*Sir Dai Rees*) The more champions we have, even the more special pleaders we have, the better and we welcome them all. At the end of the day we are funded by the taxpayer. I think we have to deliver a product but it is our responsibility that we maintain a research capacity which is in good shape to deliver tomorrow as well as today. I think David and I would be failing in our responsibility if our anxiety to please our political masters went so far as to sacrifice that ability to deliver in the longer term.

100. If you were a pharmaceutical company and you had a new product you had to produce you might set up a new plant, and launch some shares on the public to make them realise that they have to do something to support this. Someone has to make the case.

(*Sir Dai Rees*) Please.

Baroness Perry of Southwark

101. I was actually very heartened to read in your report that you were playing a useful role at local purchaser and provider level, because I think there is a great focus of anxiety on that relationship particularly down to the local level and in a sense we sometimes isolate general practitioners as fundholders. Could you tell us something about how you see your useful role and perhaps particularly in

[Baroness Perry of Southwark *contd.*]

terms of how it bears on patient care and indeed on the structure itself? Are you looking at the long term effect of the local purchaser/provider relationship and are you specifically looking at how it bears on the delivery of the patient care?

(*Dr David Evered*) If I could start again with the second component of that. Yes, the Council, as Sir Dai Rees has pointed out, does have a responsibility for taking a long and medium term view as well as the short term view of things. You will see throughout our corporate strategy the phrase "maintaining a balanced portfolio" which we regard as crucially important. If I can just add one other point about the strategy. I think it is important not to misunderstand the definition of that word "strategy". An important component of the strategy is focusing on, for instance, the training of individuals and maintaining an important response mode element, an investigator, initiator component, to the system. So strategy is not simply about identifying areas and it certainly should not be confused with direction, it is about providing a framework, a substantial element of which still maps very closely on to the way in which the Council has always operated. If I can move on to the relationship with purchasers and providers. What we are doing in the first instance is two things. First, we are trying to look at better ways of disseminating research results. Clearly again this is an area in which responsibility does not fall solely on the Council. While we can make our research results as accessible as possible, clearly they need to be carried forward and translated into practice by others. With respect to the health departments, we have very effective interactions now and indeed we have a publication—which Dr Box has here—which is entitled *Research Developments Relevant to NHS Practice and Health Departments' Policy* which was produced about 18 months or so ago and an update is currently in preparation. That is one mechanism of disseminating results to the health departments. We are, however, increasingly trying to adopt a more direct approach to the final end users of the products of our research. We have revamped, for instance, things like our *MRC News* and we are happy to leave copies of these behind at the end. This has been considerably restructured and indeed has received a great deal of praise and has made much of what we are doing very much more readily accessible to people. We are currently undertaking a trial of distributing this around general practitioners. I think there is another issue about dissemination and that is, of course, the establishment of the new centre in York for research Reviews and Dissemination which is run by Mr Trevor Sheldon. He is one of the collaborating groups for our new health services' research centre in Bristol so we have another link in with the mechanism that way and we also have a link with the Cochrane Centre and to other places. We are doing what we can to make sure that the results of our research are handed over in an appropriate manner to those who can take them forward and indeed implement them where appropriate. The other issue is how do we interact directly with purchasers and providers? The interaction with providers I think is more straightforward than with purchasers and indeed it is the major teaching provider units with which we have traditionally interacted. There is obviously a number of questions which we need to work through with them about career development, time for research, proper mechanisms for the provision of service support, which we have touched on in the earlier part of the discussion. I think the purchaser is a very much more difficult area though it is becoming a little bit more straight forward as individual purchasers are coming together to form either strategic alliances or purchasing or commissioning consortia within the new system. Some of them are now beginning to recognise that they do need to make better use of research which is currently available within the system and they need to develop mechanisms so that they can inform themselves better both with respect to their contractual responsibilities but also with a view to developing their future strategies. Also they are beginning, or at least some of them are, to recognise the need to play a role in the overall development of the system. I was yesterday afternoon at a research workshop which one of the commissioning agencies had set up as a first exploratory effort to define what its roles and responsibilities should be, not only in the support of research but also in the dissemination of research results and trying to build up the research culture within the system which Professor Peckham has set as one of his major objectives. We have a long way to go.

102. I am sure you are right to focus your main thrust on the dissemination of research but there is another step, is there not, in terms of almost an educational policy for the GP fundholder and I wondered whether you have any plans to try to spread more widely some involvement in clinical research because this would be a very effective way I would have thought, as a lay person, of involving more GPs in the sharp end of clinical work?

(*Dr David Evered*) We do have one direct entrée to a substantial number of general practices and that is we do run a General Practice Research Framework which now has nearly 900 practices signed up and participating. It slips my mind what percentage of the UK total that is.

103. I was going to say, out of how many?

(*Dr David Evered*) We can let you know that after this discussion. That is one mechanism for getting to the general practitioner. There is, as you have implied, a very much bigger question and that is the issue of effective continuing medical education for health care professionals, not only general practitioners of course, but increasingly as clinical responsibilities are being taken on to a greater extent by nursing staff, by physiotherapists, other health care professionals, this is clearly becoming a very big issue and one which we cannot address alone but one in which we need to engage with the health departments. I suspect the new Regional Offices will be important since it is suggested they will have major responsibility with respect to professional development and training.

(*Sir Dai Rees*) We do very much accept the point.

(*Dr David Evered*) Absolutely.

(*Sir Dai Rees*) The way that health care delivery is changing and so on, we do have to get much closer to GPs.

Chairman

104. Some time ago the universities found it extremely difficult to pay general practitioner teachers (because GPs are of course independent contractors) unless they were able to give them sessional lecture posts, readerships or even chairs. Have you any thought of the possibility of paying sessional fees or taking over sessions for general practitioners with a high quality of research capability to enable them to become researchers in general practice?

(*Dr David Evered*) The answer, my Lord Chairman, is no, not directly. The problem to which you alluded at the outset remains a problem and that comes very clearly out of the funding council's monitoring exercise. Clearly we do have funds available to pay those at present limited number of general practitioners who wish to undertake research training or take a research fellowship within the framework of primary care. We are at present also negotiating with respect to the service costs of research and we do meet some practice costs through the GP research framework, for instance of research nurses. We are moving to a certain extent down this road but as Lord Butterfield pointed out at an earlier stage we work within a fixed cash limit.

105. SGUMDER is charged with co-ordinating policy between the relevant Departments of State in relation to such issues. How well do you think the successor to the France Committee is functioning?

(*Dr David Evered*) Yes, I am a member of that Committee. I think in its early days it played a very valuable role and in the period leading up to the publication of the second report and the identification of the so-called ten key principles it was an essential component of the system. It has unfortunately met rather infrequently over the last year to year and a half and there have been some key issues which I think could with merit have been discussed and possibly could have been moved forward more quickly had SGUMDER met more regularly during that period of time. I think there is also another key point and that is of course SGUMDER was set up, or the old France Committee was set up, as an inter-departmental committee between the Department of Health and the then DES. Although there is an Office of Science and Technology presence there now, I would consider a stronger presence might be desirable.

106. It was first established, as I know well, in order to persuade the Department for Education and Science, as it then was, to talk to the Department of Health about these interfaces because that had not happened previously. Do you think it needs then a little revitalisation perhaps?

(*Dr David Evered*) I think that might be helpful.

Earl of Selborne

107. We touched earlier on regional divergence, perhaps we could talk about national divergence now. The Concordat sets out arrangements, consultations, between your Council and the four health departments. Would you like to tell us in what sense they are different and perhaps it would be helpful if you would tell us their relative performance in relation to the national research requirements?

(*Dr David Evered*) Clearly there is an important interface with all four of them. The department in England has clearly been expanding its investment and its structures since Professor Peckham was appointed and Sir Dai Rees is a member of the Central Research and Development Committee and we have discussed ways in which the Council interacts primarily with the English department during the course of this discussion. Scotland, of course, has had an analogous body for really quite some time, that is the Chief Scientists Committee, which operates in a way rather differently from that which the old Chief Scientists arrangements formerly worked in England. I am a member of that committee. That supports a range of work with a particular Scottish focus using mechanisms for peer review and evaluation which are broadly similar to those which the Council uses. In general we have good working relationships with the Scots. In Wales, they have invested a lot of effort in developing protocols for health gains as a basis for research relevant to the health service. They had, unfortunately for a rather short period of time, only a Director of Research and Development who was appointed and has now gone elsewhere and pending a further appointment our relationship to a certain extent has gone on hold for the time being. All these three regions have definitive R&D documents but Northern Ireland produced a consultative document about a year and a half or so ago and has not yet produced a definitive document. We did respond to the consultation. They have not yet appointed a director of research and development. I did see the Deputy Chief Medical Officer for Northern Ireland last week and I understand it is unlikely there will be an appointment in the very near future.

108. This must make it rather hard for the arrangements set out in the Concordat to be fulfilled?

(*Dr David Evered*) It is certainly true that we have much closer interactions with England and Scotland than we do with the other regions but of course the volume of activity in England and Scotland is much greater than in Wales and in Northern Ireland. I think if I might just add one other thing. In the development of the implementation of the Culyer Report I do regard it as critically important that the arrangements which are set in place should be United Kingdom wide arrangements and that individual and idiosyncratic arrangements should not be established in the different regions. There is a risk, from the discussions which I have had, that this may happen. It would make it extraordinarily difficult for the conduct of multi-centre research and indeed for research funding bodies, whether they be my Council or whether they be the major research charities which have a United Kingdom wide remit, to operate the system satisfactorily if different mechanisms are set up in the different regions of the United Kingdom.

109. I think we are now talking about mechanisms which might allow that to be a uniform United Kingdom approach. Do you feel that Culyer has identified the solution to this or what further mechanisms if any would you feel might be appropriate to getting this interaction with yourselves?

(*Dr David Evered*) Our Council has strongly supported and warmly welcomed the principles which have been articulated by Professor Culyer and

[Earl of Selborne *contd.*]

his colleagues. We have also made the point to the Department of Health that there is a number of issues which we believe need further discussion and development. One of them we have touched on, that is the tertiary referral issue. There is also an important question which perhaps needs some further thought, that is the role of a new national forum and its responsibilities and its relationship to a restructured Central Research and Development Committee. With respect to the funding arrangements, I said earlier in the discussion that it will depend upon the way the funding arrangements have developed whether they will be excessively bureaucratic or not. Clearly our wish is that they should not be and as I said at an earlier stage my colleagues are working very closely with officials at the Department to try and ensure that this is not the case. One specific issue is worth picking out in relation to the development of appropriate mechanisms for accountability. The stream of funding which will provide for the maintenance of those core facilities which are necessary for research activities should not be reviewed on too frequent a timescale. I think something like four to five years would be appropriate. I would also argue very strongly that that review process should be linked into the Funding Councils' research assessment exercise. The actuality is that most of the work in determining quality is already done and in my view with relatively minor recalibration of the system the needs can be met and met without placing substantial additional administrative burden on the university sector.

Chairman

110. Is there not something to be said for possible regional variations in the implementation of Culyer if only in order to be able to compare different mechanisms in different parts of the country?

(*Dr David Evered*) Yes, I would fully agree with that. At the last meeting of SGUMDER last month I did argue the case quite strongly for piloting and monitoring the new arrangements. In a sense we are moving from what is essentially a black box arrangement, the components of which none of us actually know, to a costed system with money which should be tracked to ensure it is used for the purposes for which it has been voted and for which accountability is required. I think there is a strong case for some modelling but an even stronger case for some effective piloting of the system.

111. We understand that the Higher Education Funding Council in England has already faced a legal challenge on its rating of a particular centre. Is there not a risk that the same kind of thing could increase bureaucracy in the NHS?

(*Dr David Evered*) It is certainly true there has been a challenge by the Institute of Dentistry which has gone to judicial review. The Funding Councils are very conscious of how time-consuming litigation might be and indeed how costly it might be, and there was a discussion some week or two back, which Sir Keith Peters chaired which he will be able to tell you more about, where it became very clear that the Funding Councils are anxious to try insofar as is possible to establish a system which will make them at least reasonably litigation-proof.

Earl of Selborne

112. I wonder if I might follow up Dr Evered's concerns or qualifications about the Central Research and Development Committee? You obviously see this as a pivotal committee but you have some concerns either that its remit is not correctly defined or its composition is not correctly defined, or that the linkage with your Council is not correctly defined. Could you elaborate?

(*Dr David Evered*) Sir Dai Rees is a member of the Committee.

(*Sir Dai Rees*) I am not sure to which concerns you are referring.

113. I was referring to Dr Evered's remarks earlier that he would like to see the Central Research and Development Committee in some way modified.

(*Dr David Evered*) I was making the point that Culyer has proposed a new body, the national forum, the precise remit of which was not elaborated in great detail in the Culyer Report. It was also suggested in the Culyer proposals that there should be a restructuring of the CRDC. I was making the point that if we are to have these two bodies in the system some further thought needs to be given to their different roles and responsibilities. It was not a criticism, simply an issue I was highlighting for further discussion and thought.

Chairman

114. Our time is almost up but I have two final questions. The first relates to the comment made by Lord Nelson's Committee in 1988 about the weakness of the UK science base in public health research and educational research, and what you are doing about that. We also note in your scientific strategy you are contributing to the debate on implementing the research component of the European Union's new competence in public health. Would you like to comment on these two points?

(*Dr David Evered*) With respect to the national capacity in public health research, we are in the process of addressing that through mechanisms like our new Health Services Research Centre, our fellowships in health services research and so forth. At the European level the present biomedical programme, which falls to DG XII in Brussels, has an attribution which is 68 per cent of the OST, 32 per cent of the Department of Health, and I represent the UK as the lead UK representative on the committee. There is generally a very good interface between the Council and the Department of Health with respect to that programme, and we have played an important role in developing its strategic thinking and particularly identifying those areas where there is a clearly added value at both national and Community level from the research which is conducted with European Union money. We have also exerted a great deal of pressure and had some success in improving the administration and monitoring programmes, and indeed the UK has done extraordinarily well out of those programmes—something like 30 per cent of the funds are coming

[Chairman *contd.*]

back to the United Kingdom, which is considerably better than the *juste retour*. That programme now has a new director, one we are working very well with, and we have some important strategic alliances with other national representatives. The programme committee has now set up a number of working parties to help define its strategy in public health research and in relation to the specific disease targets of the programme to achieve greater clarity and to help improve and refine the system even further. The Treaty which was negotiated at Maastricht of course introduced health as a competence for the Community for the first time, and there is a debate which is currently going on within DG V which has the public health responsibility to determine how that competence should be developed and its responsibilities discharged. What we have been doing is trying to develop the interface with DG V, an interface which recognises DG XII which like the MRC in the United Kingdom, has a research agenda, some of which is designed to meet public health needs but some of which is driven by developments in science. DG V of course has an agenda which goes broader than simply the research needed to underpin the development of public health policy, and we have contributed significantly to the development of a paper which articulated the ways in which the two Directorates General might operate the interface between the two, if you like something like a concordat, although concord between DGs is very difficult to achieve in Brussels.

115. The final question is London reorganisation—does this present transitional or fundamental problems? What about the effect it is having on your research strategy and funding decisions? We are familiar with one or two of the problems which have emerged, of course.

(*Dr David Evered*) I do not think I can answer your first question with absolute confidence at the present time, Chairman. We hope, and indeed have put a lot of effort into trying to ensure, the problems are transitional rather than fundamental, but there have been difficulties in resolving some of the very substantial issues in a number of the sectors within the capital, and it has proved extraordinarily difficult to ensure there has been a convergence of thinking and planning with respect to educational and research needs on the one hand and the planning of the future disposition of clinical services on the other. Having said that, there are some real opportunities. It has to be said, however, this has had a significant impact on the Council and indeed on the academic institutions in London. There has been some loss of personnel, it has not been very substantial at least as yet, and perhaps one of the factors, which I do not think we can take much comfort from, which has helped us retain at least a substantial number of staff in London is the recognition that what is now occurring in London is beginning to occur in a number of cities elsewhere in the United Kingdom. There is no doubt that although we have managed to retain at least a high proportion of the best of our staff who work in clinical research or at the clinical interface, it has proved extraordinarily difficult to recruit.

116. I am sure you would agree that in research terms the concentration of specialist units into larger groupings than exist at the moment may in the long term have considerable advantages; the exact way that is to be achieved is the problem?

(*Dr David Evered*) Absolutely, and I have been a member of the funding council's working groups looking at mergers and have been doing a lot, quietly trying to influence and nudge people in what you and I would regard as the appropriate direction.

117. Is there anything you think we have overlooked which you would like to add?

(*Sir Dai Rees*) I wonder, Lord Chairman, if I could make a point which I thought might crop up at some point in the morning but has not explicitly? I thought you were beginning to touch on it in your opening remarks when you spoke of concordats between the NHS and funding bodies other than the MRC. I would just like to distinguish between the different roles of different funding bodies. If we think of university medical departments, clinical departments, at the centre of some universe, and their relationships being with the NHS on the one hand and the funding bodies in total on the other, I think that is an over-simplification. This is because they have to relate to different funding bodies in different ways to look to different funding bodies for different things. If I can explain what I mean: it has been clear from several discussions this morning that the MRC is pressed and challenged by Government to do our best to deliver the results of our research into everyday health care, and there are pluses and minuses to this. There are problems of balance and so on, but there is no doubt about the fact we have to drive forward in that direction. We have to deliver more, hopefully without sacrificing any good things of other sorts. The second thing is that I would be surprised if university clinical departments did not feel a similar sort of pressure and a similar sort of need, not only nationally but also locally, in order to get coherence into their activities with health care delivery. They will be wishing to rise to the challenge at best or come to terms at least, so in that sense there is a similarity between what the MRC has a responsibility to do and has to do and what university clinical departments are going to have to do. In contrast, if you ask medical research charities whether they see it as part of their job to fund improvements of the health service, I think you would get an answer which would distinguish their position from the MRC. They have an important role to play, they want to promote clinical research and they can contribute to the health of university clinical departments but in a different way. It is in everybody's interest to understand those differences of position. So that when you come—and this was your point about concordats—to the framing of concordats between bodies, this distinction will have to be recognised. I would also go further, and this is the bottom line, and say that when it comes to the provision of service support for research, particularly if funds are limited, this distinction will need to be recognised there as well.

118. You would accept, though, that many of the medical research charities which are disease-orientated are really concerned specifically with

[Chairman *contd.*]

research which would ultimately lead to the better management of the disease with which they are concerned?

(*Sir Dai Rees*) Of course, yes.

119. Any other points?

(*Dr David Evered*) No, Lord Chairman, I have nothing to add. We will provide a written response to the questions.

Chairman] Thank you very much indeed. We are very grateful to you for sparing the time to be with us this morning.

Further memorandum from the Medical Research Council

INTRODUCTION

We very much appreciated the opportunity to discuss the issues with the committee; as many of the 17 questions were fairly fully answered in the discussion, this follow up memorandum will give particular attention to those not covered in detail or points where we would like to add further information or emphasise a point.

Q1. *In your memorandum (point 4), you defend the Concordat, which commits the health departments to providing service support for MRC research, subject only to adequate notice. Does the MRC have more excellent and relevant clinical research proposals than the NHS could or should be able to support? Would you expect the MRC to be exempt from the procedures proposed by the Culyer report (paragraphs 3.48, 84) for service support providers to "sign-off" research proposals in advance of project grant approval?*

A1. We consider that the NHS should be able to support excellent relevant clinical research proposals which are funded by MRC. Since the true costs of service support provision are not well documented, there is as yet no basis for assessing the likelihood of insufficient funding being available for the service support of MRC research. As the Culyer Report states that the NHS "should not be obliged to support new MRC R&D if it believes it has a better use for its money," there may be a need to plan for the possibility that not all demands for service support will be met. However the spirit of the Concordat should lead us to expect that NHS should support MRC research—especially with their involvement in the MRC Boards' funding decisions. So, whilst we would not realistically expect MRC to be exempt from the requirement that researchers' applications be signed-off by service support providers early in the peer review process—this will be an essential stage in the system proposed by Culyer—we we would expect purchasers to meet service support costs of research considered worthy of support by MRC Boards.

Q2. *Can you imagine a sort of "dual support transfer" for the NHS, whereby the research part of SIFTR would be transferred to the MRC, which would use it to pay for service support for MRC-funded clinical research?*

A2. Yes it would be possible to devise a dual support transfer whereby MRC would take on responsibility for service support and which would preserve the opportunity for NHS and HDs to influence MRC research strategy and funding decisions. This would in many ways be a very logical way to proceed; we did consider the possibility of suggesting it earlier, but realised it could prove complex, difficult to quantify and administer and was unlikely to be acceptable to all those involved. However, it could be a particularly useful way of providing and targeting service support for projects in primary care. We suggested in evidence to the Culyer Task Force that "given that in some cases relatively modest sums of money have to be allocated to a large number of general practices it might well be more efficient in relation to MRC funded work to channel funding through the MRC for the studies."

Q3. *Would you contemplate a system of "research beds" (ie beds, wards or even whole hospital units fully funded by the MRC and/or other research funders)?*

A3. We see considerable advantage in linking treatment in the NHS with research and maintaining that research is an important part of patient care—not least in helping to develop the "evaluative culture" in the NHS that seems eminently desirable to us as well as to the HDs. We would therefore not favour having research beds divorced from the NHS and totally funded by research funders. However we can see cases where it would be valuable to have the flexibility to have beds provided by the NHS for more intensive clinical research studies than would be part of routine patient care; this would appropriately form part of service support for "facilities".

Q4. *Annex 2 to the MRC's evidence to the Culyer committee describes the clinical services provided to NHS patients by MRC-funded researchers. In the absence of "knock-for knock", will you invoice the NHS for these services?*

A4. In the absence of knock-for-knock it might become necessary to consider invoicing NHS for current MRC clinical services. We would prefer not to have to do so, not least because of the likelihood that the administrative costs of doing so would be considerable; it might be preferable that the provider units concerned recognised an extra duty to provide service support for the research needs of those MRC-supported staff providing clinical services to the NHS. [There might however be a strong case for charging for additional duty hours currently paid by MRC for our junior clinical employees on call for NHS.]

Q5. *What extra administrative burden will the Culyer proposals place on the MRC, and on researchers seeking grants?*

A.5 Obtaining service support has already become an administrative burden for MRC and NHS as well as researchers. We believe a new system as proposed by Culyer could eventually reduce this substantially. However there will continue to be more work for researchers in establishing service needs and costs than was required before the NHS reforms and we recognise there is a substantial amount of administrative work to be done before the new arrangements are in place to establish the quantity and costs of service support now being provided for MRC clinical research and trials, once agreed definitions have been developed for service support. Some piloting of the scheme for providing "facilities" service support might reduce the workload; it could also help to use the Research Assessment Exercise where possible in the review of facilities.

CLINICAL RESEARCH

Q6. *Please describe briefly your Clinical Research Initiative. This Committee's report of 1988 recommended (paragraph 3.17) that "the MRC should take pains to strengthen the contribution of clinicians to its work": does this Initiative address the concerns raised at that time?*

A6. The CRI is at the heart of MRC plans for strengthening clinical research and integrating it more effectively with basic biological science. Its aims include provision of training for clinical staff wishing to acquire research skills, and for basic scientists able to respond to, and to pose, clinical problems. As well as the Clinical Sciences Centre, there is investment in Birmingham (immunological and signalling mechanisms); Cardiff (vascular disease, genetics of psychiatric disease); Edinburgh (brain injury and schizophrenia); Glasgow (heart failure); Newcastle (diabetes); Nottingham (bacterial infections). In some of these centres MRC support has been vital in ensuring that clinicians are able to concentrate on research, rather than having to combine this with a full-time NHS post.

Whilst the initiative should thus help to address the concerns about the contribution of clinicians, the first phase has been primarily concerned with improving the integration of basic and clinical research. There are current plans to build on this with further opportunities for clinical researchers *(see info in answer to Qu 7)* including increases in clinical training and career development awards which should more directly address the concerns about the contribution of clinicians to MRC work.

Q7. *How many researchers employed by the MRC (either in MRC units or in MRC-funded senior academic posts) hold long-term honorary NHS consultant contracts? Has this number changed over time, and what does this tell us about the state of clinical research?*

A7. There are currently 56 researchers employed by MRC holding long-term honorary NHS consultant contracts (including three in research professorships but excluding three in short term senior research fellowships.) This has reduced over time but, as discussed with the Committee, it would be unwise to draw too many conclusions from this fact, in isolation, about the state of clinical research as there are a large number of factors involved eg

- there have been substantial increases in clinicians receiving funding from MRC for research training fellowships (average number of annual awards before 1988 about 25; since then average almost 50 pa).
- the overall MRC funding of clinical research has not decreased and it is thought likely that more non-clinical scientists are playing a part in clinical studies (cost constraints could lead to a tendency for clinical research to be undertaken by non-clinical researchers or research nurses, under clinical supervision, where possible).
- the recent decrease in part reflects the closure of the Clinical Research Centre and there has been an increasing move to ensure MRC contributions are embedded in university hospitals.

However the fact remains that it has been more difficult for consultant clinicians to undertake clinical research since the NHS reforms, partly because of the increased administrative demands on them; this has almost certainly acted as a disincentive to those interested in undertaking research, particularly in non-teaching hospitals. There is an opportunity for this to be addressed through the Culyer proposals for a single funding stream to provide service support in all locations.

Q8. *Your memorandum (point 4) refers to the absence from the Culyer report of any proposal for protecting tertiary referrals. What would you suggest? Does not the Culyer report address this issue in paragraph 3.44?*

A8. Whilst paragraph 3.44 of the Culyer report partially addresses the issue of support for extra-contractual tertiary referral, there remains concern about provision for adequate support for tertiary referrals on common diseases, particularly for building up research clinics for exploratory, pre-protocol clinical research, where the benefit to the NHS may be rather more distant eg if the main aim is the increased understanding of disordered (or in some cases, normal) function.

Q9. *We gather that the MRC is taking forward some of the research priorities identified by the advisory groups set up by the NHS Central R&D Committee (including the Standing Group on Health Technology). Please tell us what you are doing, and how well it fits into your existing strategies. On what basis have matters been apportioned between the MRC and the NHS? Is the system of advisory groups a significant improvement on the cooperation achieved through the "stock-taking" procedure under the Concordat?*

A9. First question: we have been contributing to the NHS priority setting exercises, both by providing information on possible priority areas on which we (or others) are already supporting relevant research and therefore avoiding duplication, and also by suggesting topics of concern and commenting on others suggested; this has been helped by Sir Dai's membership of the CRDC and office observers on the Standing Group on Health Technology and other CRDC Advisory Committees. Some topics have in fact been agreed not to merit priority status because of awareness of MRC ongoing research (eg on health checks for the elderly) or because MRC work has suggested an area should not be a research priority (eg neuroblastoma screening). We have also contributed to taking forward some of the specific research priorities identified where these are appropriate for MRC funding, for example in mental health where we funded 17 projects under our Neurosciences Approach to Human Health Initiative. The basis for deciding on apportionment between MRC and NHS is complementarity, taking into account a number of factors, including:—

- the relevance of the NHS priority areas to MRC Board strategies (which are in turn informed by other users' needs);
- links with existing MRC-supported research;
- which organisation has the more appropriate expertise to assess particular applications—with the aim of maximising the amount of public funding being used to fund good research proposals in the NHS priority areas.

Second question: the Advisory Groups and the Stocktaking have different, complementary aims; the system of advisory groups provide a way of ensuring that the relevant NHS purchaser and provider inputs are taken into account in formulating priorities of genuine concern for NHS practice, and MRC participation gives us a useful appreciation of NHS research needs, and the DH an increased awareness of the relevance of ongoing research to these concerns. The Stocktaking meetings provide an opportunity for review of what has happened, from which lessons can be learned and a limited forward look, which is of necessity very general.

Q10. *The MRC funds research nationwide. What is your impression of the relative performance of England, Scotland, Wales and Northern Ireland in handling the interface between medical research and the NHS?*

A10. England has clearly been expanding their investment in work on medical research relevant to the NHS on a larger scale than the other Home Countries, as would seem reasonable in view of their larger size. Scotland has for a long time invested heavily in clinical as well as health services research in a way that complements the work supported by MRC. Wales' efforts in developing protocols for health gain has provided a very useful basis for research relevant to the NHS and a considerable amount of effort has been devoted to developing a programme that should meet the NHS' needs; it is hoped that a rapid replacement for their departing Director of Research and Development will ensure that this progress is maintained. Northern Ireland has been examining critically their mechanisms for supporting clinical research; so far they have not been able to proceed with their plans to appoint a Director of Research and Development.

With regard to service support, the other Home Countries have been proceeding cautiously, awaiting the outcome of the Culyer Task Force before setting up their own mechanisms; however the Scottish CSO has been very helpful in intervening in cases of difficulty although the current position is difficult for them. It is of concern to the MRC that the conduct of multicentre clinical trials will be made much more difficult if there should be major differences in the mechanisms developed following the Culyer Report for providing service support in the four Home Countries.

Q11. *Your memorandum (point 3) calls for "the development of mechanisms [within the NHS R&D strategy] to produce research results of long-term value to the NHS", and "increasing readiness to think in terms of the longer-term research needed to answer some questions". What sort of mechanisms do you have in mind? Does not the MRC itself provide such a mechanism?*

A11. Yes; it is the proper role of the MRC to undertake the longer-term research that is needed to answer some research questions which would have long term value to the NHS. Some of this research needs longer-term funding than the NHS R&D programme might be expected to provide, but it is vital for all concerned in the NHS (eg purchasers, providers, Regions, HD) to provide the service support costs for such MRC research even if the service applications are not immediately clear—we and the NHS Executive both have a role to play in encouraging purchasers to see the value of longer-term research, partly by increased efforts at disseminating results of research we have supported in the past and which has had an impact on the service.

Q12. *Your memorandum (point 3) says that the MRC is "playing a useful role" at local purchaser and provider level. What exactly are you doing?*

A12. Our memorandum says the MRC is playing a useful role in dissemination of research results and recognising the need to incorporate new developments into practice more rapidly. What we have been doing in relation to this includes the preparation of the publication "Research relevant to NHS Practice and HD Policy" which was provided for the Committee and has been distributed widely within DH, to Regional Directors of R&D, to Scottish Research co-ordinators etc. An updated version of this will be prepared over the next few months.

Mechanisms of increasing awareness of ongoing research also include publications such as MRC News which has recently, on a trial basis, been sent to general practices, and the increasing practice of publishing MRC reviews of specific scientific fields or topics eg "The health of the UK's elderly people".

Although we did not specifically say in our memorandum that we were playing a useful role with purchasers we have been involved in discussions with purchasers at different levels about what would be appropriate for MRC to do to help ensure purchasers' needs are effectively met. These needs include evidence for decisions on change, whether of treatment, type or level of service provision etc. This depends on having information on:

- needs asseessment—based on epidemiological evidence
- clinical effectiveness and outcomes of different treatment or service intervention
- better methodology for assessing outcome of interventions
- appropriateness of specific forms of management for different subgroups of patients
- better ways of comparing the value of interventions for different conditions
- cost-effectiveness of comparable forms of management.

It would seem that MRC has a particular contribution to make in providing rigorous, unbiased evidence for change eg by

- consciously taking account of the purchasing perspective in assessment criteria when considering Health Services Research applications, eg including economic evaluation
- promoting research aimed specifically at addressing purchasers' specified requirements. An example of this is the programme grant recently awarded for study of incontinence—a population laboratory approach to the epidemiology and evaluation of care—where purchasers have supported the importance and relevance of the research.

Q13. *Your memorandum (point 3) mentions joint fellowships in health services research funded by the MRC and RHAs. Are there other examples of collaboration with RHAs? What will happen to these initiatives when the RHAs are abolished?*

A13. Yes. Other examples of collaboration with RHAs include the development, following meeting with RDRDs, of a joint Region/NHS small grant scheme to address problems of particular concern to Regions with the rigour required for award of an MRC grant. We understand this scheme has been welcomed by Regions and would therefore hope to see it continued after the RHAs are replaced by Regional Offices and we plan to discuss this with appropriate staff in the Regional offices. The future of this and the joint fellowship scheme will also be discussed in our regular meetings with the R&D Division of DH and equivalent officers in the other Home Countries, who have also welcomed the scheme. The MRC's links with Regions have also been helpful in negotiating support for the service costs of MRC research. We would hope that such links would continue to be mutually beneficial, particularly when there is a clear definition of the future role and responsibilities of the Regions in relation to research.

Q14. *Please tell us about your Initiative in health services research (defined in your Scientific Strategy as "the investigation of the health needs of the community and the effectiveness and efficiency of the provision of services to meet those needs"). This Committee's report of 1988 expressed concern at the weakness of the UK science base in what it called "public health research and operational research": has the position improved?*

A14. The MRC Health Services Research Initiative was developed following MRC recognition of the weakness of the science base in this area and the need for increase in the quality and quantity of health services research (HSR) and an expansion of the capacity to undertake it. This initiative will complement—not duplicate—the NHS R&D activities, for example by concentrating on improving the basic methodology that is available for HSR studies and enhancing training for HSR and by providing a long term commitment to HSR studies. The MRC is also particularly well placed to undertake independent HSR studies—which might be less focused on immediate NHS needs and give more prominence to research that addresses the longer term health needs of the UK population and could be relevant to other users' needs. The Initiative includes the development of a major HSR Centre (in Bristol) with a network of collaborating centres. The network of centres includes Dundee/St Andrew's, Newcastle, Royal Free/University College Hospital Medical Schools—with MRC core funding; Aberdeen, York and Wales without such core funding.

The Science base in HSR/Public Health Research is beginning to improve but the weakness on which your Lordships commented is such that complementary efforts by MRC, ESRC and NHS would seem necessary. It is being strengthened in several ways eg:

- Public Health Research is seen as more important following the Health of the Nation initiative, and the need of purchasers following the NHS reforms to identify health needs of populations through epidemiological study
- MRC development of our HSR Committee into a new Board for Health Services *and Public Health* Research
- increased MRC support for research on determinants of health/disease, eg by Medical Sociology Unit, Professor Barket, Professor Marmot and National Survey of Health and Development
- MRC HSR fellowships and the new scheme of joint HSR fellowships with Regions

Q15. *According to your Scientific Strategy (paragraph 325), the MRC is working to strengthen research in general practice. What progress is being made? Do you welcome this aspect of the Culyer report's proposals?*

A15. We very much welcome the Culyer Report's recommendation (18) that service support funds are made accessible to professionals working in primary care. Work being done by the Council to strengthen research in general practice includes consideration of appropriate training schemes for researchers in general practice, the work being done to make our General Practice Research Framework (GPRF) larger and more representative, to increase its suitability for assessing health care provided in general practice (it now includes about 10 per cent of the UK population). Efforts are also being made to support an increasing amount of research in general practice, where appropriate, outside the GPRF. Other developments include constructive discussions with the Royal College of General Practitioners and the Association of University Departments of GP, encouragement of GPs to apply for HSR fellowships and appointment of a GP as Chairman of the Health Services and Public Health Research Board as well as a GP member of the Board. MRC is also proposing to undertake a review of its research in primary care. Current research studies in general practice supported by the Board include:—

- Evaluation of a community-based intervention to improve management of asthma.
- Assessment and management of elderly people in the community.
- Antidepressants and self-help in the treatment of mild depression in primary care.
- Randomised Controlled Trial (RCT) of alternative approaches to delivery of diabetic care in general practice.
- Comparison of out of hours care provided in general practices by own doctors and deputising services.
- RCT to increase uptake of breast screening.
- RCT of bezafibrate treatment for lower extremity arterial disease.

Q16. *According to your Scientific Strategy (paragraph 329), the MRC is "contributing to the debate" on implementing the research component of the EU's new competence in public health. How is that debate proceeding?*

A16. The Scientific Strategy was referring to the debate on the relationship between DGXII and DGV. At that time there was considerable uncertainty about DGV's intentions for research, how they would set their priorities and their likely input to the DGXII BIOMED programme. The argument is being put by MRC for stronger links between the two DGs and MRC are also working with DH on strengthening the public health component of the BIOMED programme.

Q17. *Your memorandum (point 5) describes problems arising from the London reorganisation. Do you consider these problems to be transitional, or fundamental? Are they affecting your research strategy and funding decisions?*

A17. MRC still welcomes the opportunity offered by the Tomlinson review to rationalise and strengthen medical research and education alongside the changes that are necessary in clinical service. As indicated in our submission, the decision-making process has been somewhat protracted and it has not always proved possible to ensure that research needs are integrated with service needs. The difficulties mentioned in our submission could yet turn out to be transitional if a satisfactory solution is achieved particularly for Hammersmith and Guy's/Thomas', but the tension between the need for a degree of central planning in the interests of the long-term health of UK clinical research, and the principle of allowing purchasers maximum freedom in determining service provision is a more fundamental one which might well need to be managed in other parts of the country. The difficulties have affected our strategy in London in that it has become difficult to attract quality staff for long-term programmes.

Additional information on MRC basic and Health Services Research work leading to applications relevant to the NHS

A. HEALTH SERVICES RESEARCH

The Committee expressed interest in knowing more about MRC work that has contributed new technology and approaches to health services research (HSR). The Council has had a long history of involvement in HSR [which it defines as "investigation of health needs of the community and the efficiency and effectiveness of services to meet those needs"]. Several types of research have made important contributions in this area, but the continuing need for new methodology, as well as the need for training for health services researchers, played a major part in the decision to develop an MRC initiative in HSR. A brief summary of developments follows; more information could readily be provided on any of these.

- *Development of the randomised controlled trial (RCT)* by Sir Austin Bradford Hill—major MRC-supported trials with a significant impact include:
    - MRC mild-to moderate hypertension trials demonstrating the levels of hypertension that it is effective to treat
    - cancer trials; eg, demonstrating that non-surgical treatment of certain types of lung cancer patients was superior to surgery
    - childhood leukaemia trials which have substantially improved prognosis (from almost invariably fatal when these studies started in the 1950s to current five year survival of over 70 per cent)
    - treatment of tuberculosis; demonstration that short (six month) courses of combined drug treatment as effective as 1–1½ years previously used
    - neural tube defects; trial showed efficacy of folate supplements to diet in preventing spina bifida and other neural tube defects in children of those with one affected pregnancy
    - AIDS; demonstration that the drug AZT was not effective in preventing development of AIDS in HIV-positive patients
    - low back pain; demonstration of better and longer lasting pain reduction of chiropractic rather than physiotherapy
    - planned discharge by "care attendants" with limited level of training and expertise shown to reduce numbers and days of subsequent hospital admissions

The RCT is of course a technique used widely for research funded by others.

- *Extension of clinical trial approach to health services research problems* required substantial modification of methodology, eg, development and validation of:
    - appropriate objective measures of outcome for situations where a double or single blind study cannot be undertaken and surrogate outcome measures for intermediate assessments eg, in trial of alternative policies for breast cancer screening
    - methods of assessment of quality of life and establishment of which measures are most appropriate in particular situations eg, Healthy Active Life Expectancy (HALE) being used and validated in MRC trial of different ways of assessing and managing elderly people, rather than QALYs—quality adjusted life years
    - rigorous approach to economic evaluation: cost effectiveness measurement in trials eg, of CHART (continuous hyperfractionated accelerated radiotherapy) for treatment of lung, head neck cancers—establishing methodological difficulties and possible solutions, and for developing business case for a study to show economic benefit of trial (cost per QALY of different outcomes)

- *Development and validation of rigorous instruments and measures of health status* and establishment of which appropriate for use in specific epidemiological and clinical studies; in addition to those above, these include:
    - the Present State Examination developed by the MRC Social Psychiatry Unit has been a key measure of psychiatric health worldwide
    - validation for UK use of the short form "SF36"—a widely used generic measure of health status (by Dr Brazier et al, Sheffield)
    - application of capture/recapture methods for human population studies (by Dr Bloor and colleagues at the MRC Medical Sociology Unit)
    - exploring appropriate models for national AIDS projections, including alternate hazard functions, back projections and sensitivity analysis of projections from anonymous surveys
    - methodology for developing strategy for matching kidney transplant donors
    - better use of cancer registry data by using new methodology to deal with irregularities in space and time
    - novel methodology for using longitudinal and between-district variation to help monitor Health of Nation targets (many of the above by the MRC Biostatistics Unit)
    - use of longitudinal cohort studies to establish links between risk factors and subsequent health
    - MRC supported scientists have contributed to the development of computer technology for linkage of medical records.

However, as mentioned to the Committee, there is a continuing need for long term work to develop the most appropriate methodology for particular circumstances; this is expected to play a major part in the programme of the Health Service Research Initiative centre in Bristol.

B. OTHER AREAS

Several developments with recent benefits have been covered in "MRC achievements leading to benefits in last five years" and in "Scientific developments with implications for NHS practice and HD policy". The following examples complement these.

NUCLEAR MAGNETIC RESONANCE (NMR)

MRC supported groups made major contributions to the development of NMR as a technique for clinical diagnosis, and investigation of biochemical and physiological basis of disease—and this has earned substantial royalties for the British Technology Group.

Magnetic Resonance Imaging (MRI) was developed with MRC support to Aberdeen and Nottingham Universities as a non-invasive, non-ionising way of detailed visualisation of internal anatomy. The Nottingham team introduced innovations which substantially improved the potential of MRI in clinical situations eg, echoplanar imaging (EPI) with extremely rapid exposure times to eliminate movement artefacts and provide real time images of fetus, heart beat etc. Further development with MRC support at the Royal Postgraduate Medical School led to detection of brain lesions in multiple sclerosis and functional imaging showing which area of the brain is active in particular activity, with major implications for cognitive psychology, clinical neurology and psychiatry.

Magnetic resonance spectroscopy (MRS) use in discriminating between atoms in different compounds and following chemical reactions in intact organs and tissues within the human body has facilitated investigation of cardiac and skeletal muscle disease and studies of liver and brain. This objective measure of function increases the scope for clinical diagnosis and evaluation of treatment on a sound scientific basis.

Other imaging modalities to which MRC-supported scientists have made key contributions include positron emission tomography (PET) increasingly applied in clinical neuroscience, cardiology and oncology; and positron-electron double resonance imaging (PEDRI) with the aim of imaging free radicals in vivo and studying their effects in the many disease states in which free radicals are important.

Monoclonal Antibodies were developed from MRC basic research at the Laboratory of Molecular Biology. The related, substantial advantages for scientific research have been followed by an increasing wide range of benefits for the health service. Uses include—

Diagnostic eg, in blood and tissue typing, pregnancy tests, detection of pathogenic bacteria, parasites and viruses and markers for HIV infection

Therapeutic eg anti-tumour antibodies can be used for antibody directed enzyme prodrug therapy and humanised monoclonal antibodies have been developed to tumour necrosis factor

Other Inventions which have proved of commercial value and/or valuable to the health service include:

Cephalosporin antibiotic—developed with grant support to Oxford and still the most substantial earner

Cholesterol assay developed at Clinical Research Centre for scientific and clinical investigation

Mini-Wright peak flow meter for studies of patients' lung function

Neonatal respiration monitor

Automatic syringe driver for intravenous infusion of drugs

Sacral anterior root stimulator (SARSI) developed by MRC Neurological Prostheses Unit to provide bladder control following spinal cord damage (eg, injury—paraplegia—or multiple sclerosis).

More information on any of the above developments could readily be provided if this would be helpful to the Committee.

10 December 1994

TUESDAY 29 NOVEMBER 1994

Present:

Butterfield, L.	Perry of Walton, L.
Nathan, L.	Selborne, E.
Perry of Southwark, B.	Walton of Detchant, L. (Chairman)

Memorandum from the Council of Deans of UK Medical Schools (CDMS)

The membership of the CDMS comprises all the Deans of UK medical schools. The Council considers both national and international issues that affect the teaching, research and service work of the medical schools and their academic staff. The clerk to the House of Lords sub-committee has indicated that the views of the CDMS are sought about two main matters:

(a) the funding of research and development within the NHS and

(b) the effect of the NHS reforms upon the academic medical base particularly in London.

SECTION A

1 *Research and the NHS Reforms*

The pre-reform NHS provided a particularly favourable environment for the pursuit of clinical research. The high reputation and morale of the service undoubtedly owed a good deal to its reputation for innovation (and dispassionate assessment of new discoveries).

1.1 The historic NHS-clinical research partnership.

Although the funding of clinical research was never easy a partnership grew up between NHS, the universities and the research funding agencies. The NHS provided the service infrastructure for research. University clinical academic staff normally took the lead in providing innovative ideas and seeking external funding. Higher Education Funding Council research funds allowed the more research-intensive medical schools to employ highly qualified staff, space and equipment to probe biomedical problems. The external funding agencies provided rigorous peer review and money to support these ideas, once formulated, with additional staff, equipment and consumables. Amongst these agencies the MRC (and to an increasing extent the Wellcome Trust) had a special role because of their size, universality of research topic and commitment to training and career development. The MRC, as the responsible governmental agency, also had a well defined national responsibility for the biomedical research base of the country and in addressing priorities for the nation's health.

The NHS contribution was not separately costed as most of it fell within the uncosted mutal support between the medical schools and their main teaching hospitals known as "knock-for-knock". The main University teaching hospitals received the Service Increment for Teaching and Research to assist with the added costs of their academic work and the London Postgraduate Hospitals were centrally funded. Many general practitioners were motivated to take part in research projects, particularly large scale randomized controlled clinical trials, without personal remuneration.

2 *Impact of the NHS Reforms*

The recent reforms have produced changes in attitude and financial provisions which have had adverse effects upon clinical research. Chief executives of hospitals are under pressure from purchasers to provide a greater quantity of care for the same or less money. Uncosted mutual support is being reduced or renegotiated. The central funding of the London SHA hospitals is being sharply reduced and the new performance-orientated GP contract has made family doctors less willing to participate in research without specific payment. In London the disturbance has been particularly severe because of the combined effects of the Tomlinson report, the specialty reviews, redirection of resources to suburbs and shires and the changes in the funding of the postgraduate hospitals. However, many of the changes affecting London are having a similar impact upon city centre teaching hospitals in other large conurbations.

As most clinical research workers already work very long hours the effect of greater pressure for provision of service is to reduce the time available for academic activities. Furthermore, flexibility in re-allocation of resources has been lost both because of the detailed justification demanded by a larger NHS financial bureaucracy and because of the need to convince purchasers as well as managers of the desirability of new developments. NHS purchasers have short time horizons and maintenance of the long-term research and teaching base of the nation does not figure amongst their priorities.

The cumulative effect of all these changes has been to produce an environment in which academic work concerning the advancement of knowledge or the development of new applications *is* seriously threatened. The setting up of the Culyer committee by Dr Brian Mawhinney, the Minister for Health, was a welcome recognition that a serious problem was developing that needed to be resolved.

3 *The Culyer Committee Report*

The CDMS welcome the main thrust of the Culyer Committee report and the accompanying statement by the Secretary of State for Health.

In particular they support the following points:

3.1 Ring fenced, increasing funding for research and development

The Secretary of State's commitment to ring fenced funding for research and development and her determination to increase the amount made available in subsequent years is a most welcome development. The CDMS note that the Culyer Committee has recommended that the funds at the disposal of the new program should be drawn, predominantly, from the "R" component of SIFTR and from the central NHS R&D funding of the ex-SHA London Postgraduate Hospitals plus other identifiable NHS R&D funds (para 3.36–3.38). Even here there are difficulties. The concept that 25 per cent of SIFTR is used for research has no real basis other than conjecture. Furthermore, to divert essential infrastructure funds to support research projects in other fields is not a sensible approach to managing the nations' clinical R&D. The CDMS are also concerned about the impact upon the substantial number of academic posts which are supported by NHS funds. Most of these were established to improve research (and recruitment) into disciplines such as anaesthetics, radiology, geriatrics etc which were, and are, both academic and NHS priorities. As part of the problem is funding research which takes place in a general practice setting the CDMS consider that part of the levy which makes up the total R&D fund should come from the DHH FHSAs and fund-holding general practitioners' budgets. It is the effective withdrawal of funds (time and opportunity) for research from those budgets by reason of the new family practice contract which has created part of the present difficulties.

3.2 Maintenance of the Research Infrastructure

Effective biomedical research flourishes best in an atmosphere which combines high scientific attainment with a high standard of patient care. The term academic medical centre as used on the mainland of Europe most accurately describes such an institution which requires a major concentration of medical scientific and basic scientific talent with appropriate facilities for both clinical investigation and linked laboratory research. The CDMS particularly commend recommendation 3.46 c (page 39) of the Culyer report concerning the need to maintain the research facilities and staff which provide the springboard for research projects and programs.

While the CDMS support these important recommendations, there are several parts of the report which give rise to concern.

3.3 Clinical research and health services research

The Culyer report gave emphasis to operational health services research and paid much less attention to long-term curiosity-driven research. The CDMS recognize the importance of health services research, which has been somewhat neglected. Much of such research can be fairly described as testing strategies for optimizing what can be achieved in practice from what is already known. However, long-term, science- and clinical problem-led research must not be neglected to find the funds to expand health services research. The treatment of many human diseases is still highly unsatisfactory and the opportunities for making advances are at their brightest throughout human history, because of the remarkable advances of molecular and cell biology, protein chemistry, imaging, medical engineering, minimally invasive surgery etc. There are exciting potential applications for the new genetics at the interface between the laboratory and epidemiology and public health as well as its direct application in the clinic. If the clinical and scientific infrastructure of the major academic hospital centres is not sustained our national biomedical research capacity will be seriously damaged. The effect upon industries such as pharmaceuticals and biotechnology would be adverse and might lead some to relocate R&D facilities overseas. The effect upon the NHS itself would be no less severe. There are strong grounds for arguing that the high reputation of academic medicine and research in British teaching hospitals has provided an essential leaven in the NHS bread. The Secretary of State's recent reference to poor morale amongst doctors may be traceable, at least in part, to the damage inflicted upon the morale of academic centres which provide inspiration to health personnel throughout the service. There is a risk that some of the brightest brains in British medicine will be recruited abroad if they do not have good facilities for clinical research and a working environment conducive to it.

3.4 Referral practice

All developed health care systems practise a type of progressive patient care which involves tertiary referral of patients with special difficulties to centres with a more complete range of specialist services and diagnostic equipment. The patients get a better standard of care from a more expert centre and this practice is the essential foundation of most clinical research programs. Even for relatively common disease, the local community served by any one hospital is rarely large enough to provide the patient numbers required for a serious research programme or, indeed, for the highest standards of specialist care. Given the choice many patients would prefer to be looked after in a more expert centre and freely consent to participate in research designed to advance knowledge of their illness. Tertiary referrals have been one of the early casualties of the NHS reforms and it is disappointing that the Culyer committee largely ignored the issue. The philosophy of the NHS reforms appears to be to deliver the great majority of patient care locally, in the community if possible, and if not in a local hospital. Patients follow contracts rather than "money following patients", as was promised by the reformers. Liberalisation of the extra contractual referral (ECR) procedures has been helpful but local budgetary pressures against ECRs remain strong.

A partial answer to the problem is to allow the main academic centres sufficient infrastructure research funds so that they can lower prices to encourage referral of patient with less common diseases to whose care they can make a special contribution by reason of their research. Disapproving references to "distorting the market" are unhelpful and invite the question, "what is the market for" other than in a purely Adam Smith sense.

3.5 Resource allocation

The Culyer committee paid lip service to the need to minimise the bureaucratic impact of their recommendations but they are bound to be substantial unless determined efforts are made to simplify the system. Further, the committee failed to draw a clear distinction between funding the infrastructure of University hospitals for their traditional far-ranging, long term, clinical research and the resources needed to support the direct and indirect costs of the new NHS R&D initiative.

The CDMS consider that the infrastructure funds, which provide the major component of the research base, should be ring fenced. They should be channelled through the NHS regional director of R&D to a research committee established by the medical school with its academic hospital partner(s). Only in case of disagreement between the Dean of the medical school and the relevant Trust would the regional director become involved in the detailed disposition of these funds. The Dean and Trust Chief Executive would be jointly responsible for accounting for the use of the funds. This would provide a simple method of distribution and leave the decision making to those most likely to be informed about needs and opportunities. The total available to any one centre would depend upon its performance in the NHS/Funding Council research assessments, which should be closely coordinated. For infrastructure support there should be a single assessment procedure.

3.6 Redistribution of existing resources

The Culyer Committee terms of reference precluded identification of new sources of funds ("operating within available resources"). The CDMS wish to make it clear that the re-allocation of funds which are already being used to maintain the main undergraduate teaching hospitals (SIFTR), NHS support of additional academic posts ('pseudo' SIFTR) and the London postgraduate hospitals (ex-SHAs) cannot be achieved without adverse consequences for some main University teaching hospitals and some, or all, of the London Postgraduate Hospitals. There is a great need for the cumulative impact of piecemeal NHS decisions upon the main academic centres to be assessed. The direction and rate of change could then be assessed in a more rational fashion and be implemented at a measured pace over a number of years. Too many decisions have been made without sufficient evaluation of their likely consequences, particularly on the academic and research sector. The resulting turmoil is particularly damaging to research which needs a stable platform to mount long term endeavours.

4 *The Calman Report*

The Calman report on the duration of postgraduate training in medicine, although not directly related to the NHS reforms, may also have an important adverse influence on academic medicine. The CDMS support the main thrust of this report which is intended to shorten the present very long period of training in SHO, registrar and senior registrar grades. However, the impact upon academic centres has not been given adequate consideration despite assurances that it would be at the time the report was issued.

Young doctors entering academic medicine now require training in both a clinical specialty and in a scientific discipline. Often the scientific training is obtained by spending three years in a basic science laboratory (leading to a PhD) with support from a fellowship from the MRC or one of the major charities. Under the present lengthy training arrangements in the medical specialties it has been possible to do both without a serious penalty being incurred on the timing of a senior lecturer/consultant appointment. Even with sympathetic handling by the higher training bodies the time taken for a clinical academic to reach a career appointment under the new arrangements is likely to be two years longer than for comparable NHS staff.

While the NHS may compensate for the reduction in numbers in "training grades" by creating additional consultant posts it is very unlikely that the Higher Education Funding Councils will create additional senior lecturer posts to compensate for the reduction of NHS registrars and senior registrars on academic units. As many of the holders of these posts are very active in research and teaching there will be another uncompensated penalty exacted on the clinical research potential of university hospitals. Transfer of some of the money saved on reduced numbers of training posts into support of posts in academic units would be a sensible means of moderating the effect of this change.

SECTION B. LONDON ISSUES

5 *Tomlinson and Jarman. How many hospital beds does the capital need?*

The background of current problems in London academic medicine is well known and rests on the assumption that there are (i) too many hospital beds in inner London, (ii) too many teaching hospitals in inner London and (iii) too many small specialized units offering specialized tertiary care in London. The Tomlinson report suffered from the fundamental weakness that it made no attempt at a quantitative analysis either of the then existing situation or of its own recommendations. Since that time Prof Brian Jarman has made an analysis of acute hospital bed needs in London. Jarman contends:—

(a) Looking at the inner area alone (as Tomlinson did) was not appropriate because London as a whole acts as a self sufficient medical unit.

(b) London as a whole has very few more acute beds per 1,000 people than the rest of England and markedly fewer than most other large conurbations.

(c) Rising pressure on the emergency bed service medical referee procedure, over the last decade, suggests that a serious shortage of acute beds already exists in London.

A study is now being conducted by the inner London Health Authority Chief Executives, in consultation with Prof Jarman, to try to reach an agreed data set against which policy decisions can be judged. Depending upon the outcome, this study could have important implications for planned bed closures in teaching hospitals but the pressure to concentrate tertiary services into fewer, larger, units will remain.

6. *LIG and the implementation of Tomlinson*

The London Implementation Group (LIG) has proved to be more of a policy body than one simply concerned with implementation of the Tomlinson recommendations. Indeed many of the recommendations made by Tomlinson have been extensively qualified as a result of the specialty reviews and site option appraisals. The University has been concerned to protect its teaching and research base during a period of uncertainty, upheaval and rapid changes of policy.

6.1 *Undergraduate Teaching*

The Tomlinson report recommended that an entry of 150 medical students should be removed from London. This would have been equivalent to the closure of one medical school. The University contested this recommendation on the grounds that the undergraduate entry was not disproportionate to the population of SE England served by its tertiary centres and its graduates. Against a backcloth of the need to expand the entry to UK medical schools the proposal to reduce undergraduate numbers in London seems to have been dropped.

6.2 *Research*

London represents one of the world's greatest concentration of specialist expertise and clinical research in medicine. During the LIG discussions some of the capital's leading research centres have come under severe threat. University College Hospital has partially closed and most tertiary services have moved to the Middlesex. Guy's Hospital has been recommended for partial closure with relocation of most specialist services to St. Thomas'. Hammersmith/RPMS was faced with the possibility of being moved to the Charing Cross Hospital site. At the time of writing this document the eventual shape of London academic medicine and research has not been finally settled. The most probable pattern is as follows:

SW London

St George's Hospital Medical School will remain as a free standing medical school without a multi-faculty college link.

SE London

The most probable outcome is that King's College basic medical sciences and life sciences and UMDS pre-clinical medicine will come together on the Guy's site and most specialist services and clinical research will be concentrated on the St Thomas' Hospital site. However a significant clinical research component will remain on the Guy's site in Philip Harris House. As part of this process UMDS will join Kings College. Substantial sums of capital are required for both the academic and NHS moves. Kings College Hospital, the Institute of Psychiatry and the regional Neurosciences Unit will form a focus for clinical research at Denmark Hill.

NE London

The Royal Hospitals Trust has decided to concentrate most of its tertiary services from Bart's and the London Chest on the Whitechapel site. The building stock on that site, both hospital and medical school, is of poor quality and a large capital program will be required to redevelop the London Hospital as the main academic medical centre of the merged Queen Mary Westfield College school of medicine. The academic objectives of the new QMW medical school cannot be achieved unless the capital for the Whitechapel redevelopment is made available without delay.

NC London

University College and the Royal Free Hospital Medical School have made good progress towards merging their medical schools. The Institute of Child Health, the Institute of Ophthalmology and the Institute of Neurology will also merge with University College. The eventual shape of the hospital provision in Bloomsbury remains somewhat uncertain. The favoured academic option is to re-build a medium sized teaching hospital in close proximity to University College in Gower Street while making maximum use of the new facilities in the Queen Square Hospitals (Great Ormond Street Children's Hospital and the National Hospital for Nervous Disease).

NW London

Much depends upon whether the funds are found for the new preclinical building for Imperial College at South Kensington. If this scheme goes ahead the existing preclinical schools at St Mary's (already part of Imperial) and the Charing Cross-Westminster medical school will move to South Kensington and the two schools will form the undergraduate wing of the Imperial College of Medicine. On the postgraduate side the situation is less clear. The National Heart and Lung Institute has reached agreement with Imperial about its affiliation to the College and discussions with the Institute of Cancer Research are continuing. The RPMS is awaiting clarifications from Imperial about its intentions concerning the academic hospital and clinical research centre. The number of large teaching hospitals in NW London (compounded by the recent opening of the Chelsea-Westminster) makes it even more difficult to devise an agreed strategy in this sector than in the others.

The prevailing uncertainty has had adverse effects. Clinical scientists from outside London are, understandably, somewhat concerned about moving to London. There is some evidence of an increased rate of departure both within the UK and overseas. Public bodies and major charities are cautious about committing large resources if facilities, or senior scientists, may be lost due to site closure or re-designation. The University, and the UFC Medical Committee, gave ample warning of these difficulties but in the initial enthusiasm for the internal market little attention was paid to them. For several sites the next few years may prove rather difficult while extensive building programs are brought to fruition. The worst outcome would be that the present government did not release sufficient capital to implement the changes speedily or a successor government halted them in midstream. The NHS must recognise the fundamental importance of the clinical academic base to its present quality and its future strength. There are welcome signs that this point is beginning to be understood.

Provided that the different schemes can be completed by about the turn of the century London should emerge with five of the largest and strongest medical schools in the country. Four of the five will have a pre-clinical science base in a multi-faculty college. Each will probably have one major academic hospital research centre and one or more other large teaching hospitals associated with it. An enlightened government might wish to protect London academic medicine through this phase of transition so that it can remain a world class medical centre into the next century.

SECTION C. OTHER ISSUES

7 *England and Wales outside London*

The difficulties for the main university hospitals in London have their counterpart in most other large conurbations. Main university hospitals are usually located close to the centre of conurbations but often in areas which have a relatively small residential population. Hospital rationalisation and closure are a feature in most large cities with medical schools. Funding Council capital available for dealing with the academic consequences of health services rationalisation appears to be quite inadequate and health-led schemes may not accord with their priorities. As in London there is an urgent need to find the necessary capital for reprovision before closures take place.

8 *Scotland*

The Culyer recommendations do not formally apply to Scotland and, thus far, there is no indication of any change in the distribution of ACT (the Scottish equivalent of SIFTR). The problems of inner city teaching hospitals are present in both Glasgow and Edinburgh.

Second memorandum from the Council of Deans of UK Medical Schools (CDMS)

This second paper from CDMS to the House of Lords sub-committee is a further consideration of the effects on the academic medical base outside London of the NHS reforms, both in general and with particular reference to the possible implementation of the Culyer recommendations on NHS Research and Development.

In January 1993 the Secretaries of State for Health and Education endorsed the recommendations of the Third (interim) Report of the Steering Group on Undergraduate Medical and Dental Education and Research which included the **Ten Key Principles** (*not printed*). These Key Principles have been fundamental to the Medical Schools in managing the changes following the implementation of the NHS reforms. The consequences of the further implementation of NHS reforms including the internal market and strategic planning, the extension of General Practice Fundholding and the proposals of the Culyer report are moving in a direction which increasingly compromise the integrity of the Ten Key Principles.

This paper draws attention to and expands on this serious concern. The NHS reforms have created a market where the contracting process requires money to follow the patients. Purchasers divert money to provider units on market principles—basically price. This leads to a negation of earlier strategic investment by both the NHS and the Medical Schools and also precludes current and future strategic planning by the NHS and Medical Schools.

The effects of the NHS reforms have to be understood in the context of Medical Schools as fixed points in the local community and attached, even imbedded, in the University Hospitals with whom they are associated. The current trends in the purchasing process reflect uncertainty and this is eroding confidence in the future and developmental thinking in academic medicine. The predominantly finance based and finance-led drive to purchasing may or may not reflect adequately consideration of quality of service and the longer term needs of teaching and research.

Case Study

In University Trust A, the academic department of Orthopaedics is highly rated and practises bone tumour surgery, bone transplants and complex joint revision surgery. The academic staff are funded by the NHS (originally by the Health Authorities) now through the Trust. The Purchaser using purely commercial considerations based on average costs of routine orthopaedic procedures removed £100,000 from the Trust and moved the "business" to Trust B. Whilst this did not raise issues of making clinical academic staff redundant it created a major crisis of confidence and a significant campaign was required to retain the clinical academic staff at all levels in the Department.

Additional Funds to support Teaching and Research

The countervailing influences are the extra income to University Trusts based on the number of undergraduate medical students costed at ca £37,000 per student per clinical year (3 years) which includes a notional research related element set at 25 per cent of the £37,000. Thus the University Hospital(s) associated with a medium sized Medical School with a Dental School might have a Service Increment for Teaching and Research (SIFTR) of ca £240,000,000 pa of which £6,000,000 is notionally research related.

The extra costs of "Teaching" Hospitals were never explicitly developed from a bottom up approach but simply reflected the reality of 75 per cent of actual median excess costs of these hospitals compared with District General Hospitals. It was only later that a notional 25 per cent was attributed to an R element when it was mistakenly believed that SIFT at 75 per cent of the median excess cost was too generous. At the time of "identifying" a research element, SIFTR was nominally reset at 100 per cent of the median excess cost of Teaching Hospitals but in real terms the SIFTR sum was only increased by 2 per cent. Consequently there has never been an additional 25 per cent top-up to the original SIFT. Any removal of the notional R element of SIFTR as recommended by Culyer, will remove sums of money already being spent since SIFTR is formula derived from the excess median overall costs. The Culyer recommendation for removing the R element to the R & D Directorate of the NHSE, presupposes that the excess costs in University hospitals of teaching and clinical research can be readily disaggregated. There is a clear opinion in the Medical Schools that the excess costs of the University Hospitals are as much related to the numbers and quality of clinical academic staff for which student numbers have been an "approximate" proxy. This proxy probably holds true except for a small number of very research productive Medical Schools.

Specific effects of the Reforms

Against this background it is helpful to examine further the effects of the Reforms upon:

i patient flows

ii hospital provision

iii pressures upon staff to increase clinical service productivity

iv the effects any diversion of the currently denominated R element of SIFTR (the £6 million in one Medical School and its University Hospital vide supra).

i Patient Flow

The effect on referral patterns through contracting alters the provision of clinical service. If this causes the clinical service to move away from the main clinical base of the Medical School both teaching and research are qualitatively and quantitatively vulnerable. The dramatic effects of contracting hitherto confined principally to London will, if not managed adequately cause similar major perturbations in teaching and research throughout the rest of the United Kingdom.

Large scale studies of relatively common but important conditions carrying significant mortality and morbidity are imperilled by the inability to ensure either initial or continuing attendance of sufficient patients to make such studies qualitatively credible and statistically valid eg studies in hypertension, ischaemic heart disease, diabetes, asthma and eczema. The Heads of departments of Dermatology have expressed formally their concern about the future of well-conducted clinical research following the NHS reforms. Such clinical research studies have been a characteristic strength of British medicine compared with North American medicine and have very important beneficial implications for improved health throughout the country.

ii Patterns of Hospital Provision

As patients are diverted from one Trust to another the ability to teach and conduct disease related research in a relatively stable environment are correspondingly diminished. Most of our Medical Schools have fixed bases related to their home universities and thereby can take advantage of the biomedical strength within them. It is vitally important that these linkages are preserved. It is noteworthy that in London the planned reorganisation has a particular objective of bringing the teaching hospitals closer to collegiate science bases. The purchaser strategy could have the reverse effect if applied freely outside London and seriously impair biomedical and clinical research in the Provinces.

This is even more striking in University Hospitals where medical schools are in embedded accommodation and it is often difficult to define the boundaries between Medical School and Hospital. In our view unscrambling of these physical relationships is the result of **knock for knock** (mutual uncosted benefit arrangements) coming apart with consequent damaging effects on achieving the added value of being on site with respect to facilitating clinical research.

Unfortunately hospital realignments have taken place guided by Health Service needs alone or to the extent where the needs of biomedical research and teaching are given a much lesser priority. NHS Chief Executives at Regional level are aware of this problem and have worked to mitigate the effects. However the purchaser provider split and the reality of Trusts exercising independence has made their intervention difficult because of a perceived lack of authority to exercise strategic control or even influence.

Current examples include siting Children's Hospitals away from main University Teaching Hospital sites (Birmingham), separation of clinical neuroscience from basic neuroscience on the main site (Manchester), an unplanned third site development of cardiac surgery in spite of major strategic investment on two sites (Trent). These developments have vitiated the added value for both teaching and research that would have occurred by exploiting and maximising the resources for the developments on a single or contiguous site in relation to the Medical school and main University Hospitals. The advances in biomedical science typically in molecular biology are poised for transfer to clinical applications. This example of technology transfer is not helped by the separation of eg clinical neuroscience from basic clinical biomedical neuroscience or unplanned development of cardiac surgery away from developmental clinical cardiovascular science.

Where conjoined services have been preserved there is already developing evidence of benefit eg cancer services in Birmingham and cardiovascular science in Leicester, clinical pharmacology in Liverpool, imaging in Nottingham and diabetes with renal and ophthalmological disease in Manchester.

The Calman report on the urgent need for integrated cancer centres is a benchmark for the future and draws attention to the need for coterminosity of clinical and biomedical approaches to disease.

Capital Cost reimbursement

Where the NHS moves its clinical services, the medical schools must necessarily follow suit and it is worryingly unclear how the consequential moves of university facilities are to be paid for and on what timescale. There is well documented recent evidence of the destructive effect on the retention of high quality scientists and other staff in the face of uncertainty about the future funding and siting of displaced academic units following the relocation of clinical services. Difficulties have become apparent and are anticipated as a result of actual and suggested moves of NHS services in cities such as Birmingham, Edinburgh, Glasgow, Manchester and Newcastle. Resolving these difficulties seems to depend upon local initiatives and good will rather than national policies.

Over and above the real uncertainty about who, if anybody, will fund the costs of the consequential need for relocation of academic units, the effect on morale and the disruption to established high quality research programmes must not be underestimated.

iii Pressures on Staff

There are a number of increasing pressures on University clinical academic staff and NHS clinical staff who work in University hospitals and who shoulder a significant teaching load. These staff were appointed to their posts in the first place because of inter alia their track record in research and their aspiration to continue in clinical research.

Firstly managerial pressure on both groups of staff to increase the "work-rate" will reduce inevitably the amount of time which can be spent on teaching. Consequently research is likely to be particularly severely curtailed because of the need to meet the increased demands of teaching with the introduction of the new student centred curriculum, small group teaching and integration of pre clinical and clinical teaching from the outset of the course. Therefore it will be time for research that is most at risk and is very likely to diminish the quantity and quality of biomedical research in clinical medicine. The evidence is there of the decline of British citations in clinical and related research. It necessarily follows that the introduction of overt performance related pay or covertly through the modification of the Distinction Award system will even further demotivate research and also teaching.

There is disturbing evidence already of difficulty in recruiting to academic appointments in main clinical disciplines such as surgery, orthopaedics, anaesthetics and obstetrics. The pressures described can only exacerbate these problems which could lead to the future disappearance of any academic base for some of these specialties. At present retention of high quality academic clinical staff in these disciplines is problematic.

Recruitment to junior academic staff posts where clinical research training is obtained is being put in jeopardy by the uncertainties about the implementation of the unified training grade within the NHS. It is not yet apparent that the necessary allowances are being made for clinical academics in research. The likely requirements and shortening of minimum training duration will decrease the present opportunities for future NHS consultants to gain significant experience in serious clinical biomedical research.

iv The Culyer Report

We welcome the notion of better funding for NHS R & D and the extension of opportunities for NHS R&D into Primary care. However certain key proposals in the report have raised major concern in the Medical Schools and their associated University Hospital Trusts.

We have made reference earlier in this paper to SIFTR and drawn attention to the damaging effects of removing the notional R element from the University hospitals and the informed regional allocation process. Since implementation of the NHS reforms, Trusts have taken over the funding of clinical academic posts previously supported by the Health authorities. Indeed until the publication of the Culyer report there had been new clinical academic posts funded in this way to the mutual benefit of the NHS and the Medical Schools. We are now informed that the proposal to withdraw the R element of SIFTR not only has put a stop on some developments in the pipeline but also has caused Trusts to review their commitments to support existing posts. This should be understood against a background of Trusts already withdrawing support for clinical academic posts because of the market pressures.

Information presented by the Medical Schools to the UK Joint Medical Advisory Committee of the Higher Education Funding Councils reveals that outside London NHS funding of clinical academic posts is in the range of 35 to 60 per cent staff in individual medical schools. The situation is alarming and the potential consequences of withdrawing the R element of SIFTR cannot be ignored. There is considerable scepticism about the prospect of that money being recycled in an equitable and consistent process that would allow, let alone encourage, University Trusts to support clinical research.

The report furthermore concentrates its priorities toward the field of Health Services Research (HSR). Medical Schools are predominantly prosecuting clinical and clinical biomedical research in University trusts. This reinforces the concern that the loss of SIFTR to the Trusts will be an inevitable consequence of any allocation process from a single stream of centrally directed R&D funding.

The proposal of a quasi Higher Education Funding Council Research Assessment Exercise (HEFCE RAE) to inform NHS R&D funding raises concern about the size of the likely administrative infrastructure that will be required. Medical Schools currently carry the burden of HEFCE RAE, General Medical Council (GMC) inspections and also visitations and Higher Education Council Quality Inspections (HEQCE) of Teaching. These are concurrent with Specialist Advisory Committee (SAC) inspections for the Royal Colleges. The prospect of a round of University Hospital research assessments has not been met with enthusiasm although some merit in the underlying concept is recognised. It will be inevitable that clinical academic staff will shoulder the major burden of any NHS R&D directed research assessment exercise.

There is a strong view that the role of the regional office in the NHS R&D programme has been understated although the format to the changes in the job description for regional R&D Directors has caused some concern. Hitherto the majority of R&D directors have been credible figures in biomedical science and drawn largely from amongst clinical academics. The new posts are framed for full-time appointees who by definition will be removed from the active interface of research whether biomedical or clinical research.

We believe that the Culyer recommendations need further consideration before effecting any implementation because at present the price to be paid for a better NHS R&D programme in the future may be exacted at too high a cost from well established and developing high quality clinical research in the University Trusts.

CONCLUSION

We believe that unless the need to make protective provision, albeit accountable, for the clinical bases associated with our medical schools is recognised, there will be progressive erosion of the critical links between the university biomedical science base and academic clinical work. We are unconvinced that the current level of SIFTR funding alone—even before any removal of the notional 25 per cent by the Culyer recommendations—does this.

10 November 1994

Examination of witnesses

PROFESSOR SIR COLIN DOLLERY (London), PROFESSOR CHRISTOPHER EDWARDS (Edinburgh), PROFESSOR MICHAEL LANGMAN (Birmingham), PROFESSOR PETER RICHARDS (Chairman, CDMS, London), and PROFESSOR JOHN PATTISON (London), Council of Deans of Medical Schools, were called in and examined.

Chairman

120. Good morning. Before we start the questions may I just ask whether you would wish to make an introductory statement to the Committee?

(*Professor Richards*) My Lord Chairman, we would be happy to go straight ahead with the questions.

121. Thank you, because I think you have set out your views very clearly in the documents you have provided for us. The first question then does relate to the issue of SIFTR and the suggestion in the Culyer Report that 75 per cent of SIFTR might perhaps be attributable to teaching costs, except in dentistry, and 25 per cent to research. You say this is pure conjecture. What do you think would be a more realistic ratio and do you believe that SIFTR as at present defined is inadequate?

(*Professor Sir Colin Dollery*) Lord Walton, as I understand it the basis of the 75:25 per cent split was as follows: that originally when the excess costs of teaching hospitals were calculated they decided to impose an efficiency gain and only fund 75 per cent of that so that was the money made available. Then some years later they recalculated what the excess cost was and surprise, surprise, it had fallen to the figure that was being funded. That was then called 100 per cent. Some people were misled into thinking that meant the original 25 per cent had been restored but it had not. At the same time a small addition was made, from memory only two or three per cent, and it was then extended to cover "R" as well as "T". So by a kind of logic, which I do not think is intellectually defensible at all, it was held that because what was 75 per cent had now become 100 per cent and it covered "R", that somehow the 25 per cent, which actually did not exist, it was only two per cent, was the "R" component. I think that is a correct account of it. Leaving aside the history, we do not have reliable figures to be able to advise you of what the correct percentage is. It is the view of some of our colleagues, for example Sir David Weatherall in Oxford, that a more appropriate split might be the other way, that much more of the excess cost to the teaching hospital is attributable to its research mission than purely to its teaching mission. There are

[Chairman *contd.*]

no detailed analyses that we can produce to say that. It is my view that the split is, certainly in the more research intensive hospitals, very much more in favour of research than 3:1 will imply. The second part of your question is about whether it is adequate or not. I have sat intermittently on what used to be called the France Committee or the SGUMER, the steering group, which brings together the Department of Health and the Department of Education. That Committee has a statistical working party which has attempted to address this issue. The first attempt produced a figure suggesting that SIFTR was only half what it really ought to be, but the calculations did have some very odd aspects to them. For example, it appeared that the excess cost of teaching was greater in a non-teaching hospital than in a main teaching hospital and for that reason that finding was rejected and the working party went to work again. At the last meeting of SGUMER we were told that they had now concluded that SIFTR needed to be supplemented by about £135 million to bring it up to what it should be and that in the light of Culyer they were not proposing to produce all of that but only a third of it, so that is the 40-odd million that the Secretary of State for Health has announced to supplement SIFTR. The given reason of SGUMER for not producing the other proportion, the other two-thirds, is at the present moment SIFTR is distributed in accordance with undergraduate student numbers and under Culyer it will not be distributed in that way, therefore they do not want to give the money to some institutions and then take it away again promptly, so the other two-thirds has been reserved for allocation when the Culyer mechanism is in place. That, I think, is the basis of the Secretary of State's announcement. The Secretary of State could also state in her statement that more or less she had decided that 75:25 per cent would be the split.

122. Was it your understanding that that additional £40 million was to be attributable to the research component of SIFTR?

(*Professor Sir Colin Dollery*) It is of course, my Lord, not strictly speaking an additional 40 million, it has been, or it is to be, taken away from the purchasers of the main teaching hospitals and put into SIFTR. It has not been, as I understand it, but I stand to be corrected, informally allocated to "T" or "R", it is just an overall supplement to SIFTR.

123. Your belief is that it is redistributed money rather than new money?

(*Professor Sir Colin Dollery*) There is no doubt about that, I think. It does have two consequences, both of which are useful. One is that it removes money from purchasers and puts it more in the hands of the teaching hospitals which gives them a greater flexibility. The other consequence, which I had not appreciated originally but Colin Reeves who is the Director of Finance of the Management Executive pointed out to me, is that it does lower the amount of money in the hands of purchasers and therefore if a purchaser is a net loser under weighted capitation it means that they are less vulnerable to loss because they have got less money in their hands to lose. It does in fact have two quite useful consequences.

Lord Perry of Walton

124. Do you believe that however hard everybody tries, including all the medics and the accountants, it is impossible to divide research and teaching?

(*Professor Sir Colin Dollery*) I perhaps ought to turn to my colleagues, Lord Perry. As you know there have been one or two attempts. There was an attempt in Southampton, a fairly detailed attempt several years ago, to try and find out what SIFTR was spent on and the answer that came out was that some things are easy to define, where there is a pathology contract, where there are shared costs of premises and security and so on, there are identifiable elements but they account for well under half of SIFTR and the main component simply goes into a general subsidy on costs to provide better records, better X-ray facilities, better pathology, better nursing and so on. My own opinion is that you could arrive at an attribution for "R" and "T" but the largest component of that would be guesstimates rather than strict calculations.

Chairman

125. Would it be a consequence of what you have just said a few moments ago that if the money is taken from the purchasers and given to the teaching and research providers, the teaching trusts would in a sense then be required to pass the money back to the purchasers by reducing their prices for treatment?

(*Professor Sir Colin Dollery*) That is my understanding of exactly what the rule will be. Whether they have simply to reduce their prices across the board or whether they are allowed to differentiate, I think this is something which may come up later in your questions because it is our view on this side of the table that in the use of the "R" component of SIFTR, one of the most important things should be to allow the main university hospitals to operate a differential pricing regime so that they can encourage the referral of patients, who are important to research programmes, but I am not sure whether that is envisaged or whether the purchasers are expecting that there will just be a general subsidy on price.

(*Professor Pattison*) I think that is a very important point, Lord Walton. It is crucial to most of the big research and teaching centres that they be allowed to have a differential subsidy on the price to encourage the referral of those patients they need.

126. That carries us really into the Culyer report's proposal that clearly research-driven extra-contractual referrals should be eligible for national or regional funding. What is your view about that, because we have had concerns expressed over the diminution in the number of tertiary referrals to centres of excellence?

(*Professor Sir Colin Dollery*) I think, Lord Walton, that that concern is legitimate. Our understanding is that obligatory referrals, if you like, such as to cancer centres or cardiac centres have not been very, if at all,

[Chairman *contd.*]

affected, but the "problem-case" referral has diminished substantially. Some main teaching hospitals have said it has been reduced to only just over half the flow from more distant centres than used to exist before. Our view is that patients are not at present in this country referred for research; they are referred because of the expectation of the referring doctor and patient that a higher standard of care will be offered, that a more expert opinion will be available, and, as you will know from your own experience, you need a large practice to select the patients who are appropriate for research. So simply saying that you want, let us say, patients with lupus erythematosus who have cerebral manifestations (to take a relatively uncommon disease that we are doing research on), that would be difficult, whereas if you had an expert centre on lupus and related diseases that was drawing in a large referral, then patients suitable for research would arrive as part of that practice. I think that is the difficulty. In the United States the clinical centre of the NIH has attempted to operate on the basis of offering, in that case, free care to people who are referred to it, but the clinical centre of the NIH, I understand from the journal *"Science"*, has been having difficulties even in that environment.

127. We wondered what you meant by saying that "to divert infrastructure funds to support research projects in other fields is not a sensible approach." We appreciate the concern which is evident throughout your two memoranda that the infrastructure available to support curiosity-driven research should be protected and preserved and that the money in the "R" budget should not wholly go into health services research. We appreciate your concerns but I wonder if you can clarify that particular point for us?

(*Professor Richards*) My Lord Chairman, may I preface my reply to that question by saying that the Secretary of State has a statutory duty to provide facilities in the NHS for undergraduate teaching and for research, and research has long been coupled with undergraduate teaching because it has been accepted that it is highly desirable that doctors should be educated and trained in an environment of critical enquiry and university teachers, of course, have a contractual obligation to undertake research. The "R" element of SIFTR is designed to offset the excess service costs associated with research infrastructure in the main university hospitals. In essence, the purpose is to maintain the academic hospital as both a teaching and research centre and it is not a resource designed to fund the direct costs of research in university hospitals, nor has its remit extended outside the academic health service complex of university hospital and medical school. Culyer calls for the "R" resource of SIFTR to be consolidated in a common stream of resource for research and development in the NHS and the resource would be administered by the regional directors of R&D without any indication that the "R" of SIFTR would be earmarked within that for its current purposes. Nor is an undertaking given that the joint requirement of the Secretaries of State for Education and for Health that the allocation of the SIFTR element should be by agreement between universities and health authorities would continue to be honoured. It is, in the view of the Deans, essential for the survival of strong academic health centres as a powerhouse of medical teaching and research that the current SIFTR resource should, be increased as necessary to achieve its intended purpose, continue to be regarded as a national resource linked to the education of doctors. That does not come strongly through the Culyer proposals. Our proposals for the allocation of the research element of SIFTR by the universities, taking account of a national formula, would ensure that the major university hospital of each United Kingdom medical school had a basic clinical research infrastructure in which peer-reviewed clinical and bioscience research could be built and within which excellence in research at any one time would be recognised by a selective activity-related resource: there are these two strands. You go on to ask whether our proposals are compatible with the proposals of the Culyer report and I could say something on that if you wished.

128. If there was no earmarking of the "R" component along the Culyer lines, how else might a differential pricing system as between centres of excellence, on the one hand, and district general hospitals, on the other, be achieved? I wonder, too, whether your proposal suggesting that the money in the "R" component might, as it were, go to the universities for allocation by a committee headed by the Dean, might not in many ways emasculate the authority of the regional directors of R&D?

(*Professor Richards*) If I can take the second part first, the regional director of R&D would need to be a member of that committee and so might, indeed, key purchasers and providers be members of it. The intention would not be to act in total isolation from the overall strategies of the health service but on the other hand not to be totally bound by them. We are concerned not to be in a situation where the economy of the main university hospitals was seriously threatened by having a major resource withdrawn and not totally re-injected, albeit totally re-injected in a targeted form which we would commend. We worry that there may be a leak in the system.

Lord Butterfield

129. A very brief digression: when I started at Cambridge we had some SIFTR funds and I have to tell you they were spent largely by matron hiring nurses to stand in out-patients making sure that the medical students and the patients did not get up to any mischief, and that was a terrible example of allocation of other funds or allocation of educational funds to service affairs because they did not stand for long, they went off and did other work. Obviously if things are improving I hope you will get your Committee, and I do not think you will emasculate the regional research and development directors, I think you will help them, but it would be interesting to know your views about the number of academic posts which have been supported by NHS funds. We were very fortunate in East Anglia but is it something which is gathering momentum generally? Is there a

[Lord Butterfield *contd.*]

better understanding of the needs for NHS funds in medical schools?

(*Professor Edwards*) The answer is this is an extremely important area and the figures which are available at the moment suggest that the number of academic posts supported by NHS funds is very variable different medical schools. It ranges from something like 20 per cent of the clinical academic staff funded by NHS funds up to 58 per cent. So across the country the impact of the removal of funds would be very different: in some medical schools there would be relatively little effect, others would be greatly affected by it. I think we also recognise that in some medical schools this does appear to come out of an "R" component whereas if you look in others a major part relates to cost sharing agreements with the health service. If we look at the other externally funded clinical academic posts, again this is an incredibly important area because to a certain extent the more successful a medical school is in terms of research the greater the penumbra of additional clinical academic posts. So if you look at a place like the Royal Postgraduate Medical School, for example, there is a 24 per cent core of university key posts which are funded by the Funding Council and the rest is penumbra. That is true of all the major and most successful medical schools in terms of research. So we do have to recognise that support from the health service is important in certain areas but also that provided by other organisations such as the Wellcome Trust, the MRC, other major charities, pharmaceutical industry endowments, etc.. These are key to providing this penumbra which is essential to clinical research.

Chairman

130. Have you encountered any problems over managers requiring an excessive component of service commitment on the part of those academics who are funded by the NHS?

(*Professor Edwards*) Yes, we have had this problem. I think it is a very difficult problem because to a certain extent there is an initial perception that people who are funded by this route are going to be different. We have been very strongly resistant, as I think have been virtually all of my colleagues, to that attitude. What we have tried to do is to persuade the NHS is that these people even though they have a reduced clinical commitment have a major added value. Almost invariably if you make the right appointment you are bringing in people who will more than fulfil the clinical commitment. So if you burden these people from the word go with an extra service load, you will find that they will not do that. I think both sides can achieve their ends if it is handled sensibly.

131. Speaking as a former Dean, one was always aware of the fact that if you had a disaster area in the sense of an inadequate specialty which was not doing its job in teaching and research, then the right thing to do was to create a chair and supporting staff to upgrade it. It worked time after time.

(*Professor Edwards*) Yes.

Lord Perry of Walton

132. If you take the penumbra you talk of, is there any clue as to what proportion of these non university jobs are NHS appointees compared to all the other areas externally?

(*Professor Edwards*) Well, as I have indicated it is incredibly variable. Sir Keith obviously has got particular figures, for example, from Cambridge. Here you have a situation where there is a very large NHS investment which has been handled, I think, in a very successful way. If one looks at a number of other medical schools you will find that there is an NHS investment but the pay off in terms of research has been very, very much less. I think it is so variable around the country it is quite difficult to give you any kind of meaningful overall figure.

133. In Cambridge I would imagine as well as a lot of NHS funds there must be an awful lot of funding by external sources as well?

(*Professor Edwards*) Absolutely.

134. They would be bigger in number than the NHS?

(*Professor Edwards*) I would have thought that the NHS is Cambridge's largest contributor in terms of recurrent funds for non HEFCE salaries. Cambridge has, I believe, £5 million of recurrent salaries from this source.

Chairman

135. I think we would like to have some figures on this as best you can provide them. May I also say that about 20 years ago it was said that it was impossible to transfer funds across the divide between the NHS on the one hand and the Department of Education and Science on the other; thank goodness that barrier has broken down after the France Committee was established.

(*Professor Sir Colin Dollery*) It is worth pausing a moment on why this very large development of NHS funded posts occurred. I think there were three main reasons. The first was that during the mid 1980s when the UGC funds available were capped and the medical salaries were still going up with inflation, the number of clinical academics supported from UGC funds fell, it fell by about 20 per cent altogether, and the health service moved in to the rescue and created large numbers of senior lecturer posts to fill that gap. The second reason was that there was quite a long period of time—15 or 20 years—when the health service wanted to see academic units in geriatrics, in radiology, in psychiatry etc, created and came to the universities and said: "If we give you the money will you establish a chair or senior lecturer in this discipline" and the universities usually responded positively to that initiative. The third has perhaps been more recently when there has been no money for development on the university side when the universities have gone to the health service and said: "We desperately want to develop in this area, will you help?" My worry is that there does not seem to be a clear mechanism for sustaining those posts in the new era because this was essentially regional health authority money.

[Chairman *contd.*]

136. I take it, however, that you are not proposing that in future a move should take place towards funding all clinical academic posts from NHS funds?

(*Professor Sir Colin Dollery*) We are very clear that we wish that clinical academic medicine should remain firmly in the university.

137. The Secretary of State for Health has stated her commitment to continuing support for the universities; do you have any observations on what mechanisms should now be developed in the light of the impending disappearance of the regions as funding bodies?

(*Professor Sir Colin Dollery*) It is very difficult, my Lord, and I have a general doubt about the wisdom of some aspects of that policy because in a sense medical schools are national institutions not local ones and one feels that there ought to be national mechanisms equivalent to the HEFCE national mechanism for that route for the health department to sustain its interest in the viability of the medical schools. It does appear that the Bill which I think is shortly to come before Parliament to abolish the regional health authorities will essentially abolish that mechanism. I always hope that common sense will in the end prevail and that the new regional offices of the NHSME will in fact be given functions which allow them to continue things such as the support of these kinds of posts. I am not clear that such a mechanism has yet been devised.

138. One of the strengths has been the regional planning which has, in fact, prevented hospitals from going out of line and creating quite inappropriate departments for the super specialties.

(*Professor Langman*) Lord Chairman, it is worth pointing out in our regions where trusts have not yet come fully on stream that there is a very urgent drive to get the strategic direction right before they are implemented. This tells us about what will happen in the future.

139. If the research element of SIFTR is not any longer to be distributed in proportion to undergraduate numbers and the special health authorities lose special funding, there will be winners and losers among the medical schools. How do you expect the final outcome of this process of redistribution to occur and do you think it will be an improvement on the present position or not?

(*Professor Pattison*) I think the answer to your specific question in 6 is that in principle, yes, it could be an improvement but it is very difficult to predict that until we know the details of how the allocations will be made. I think we have already this morning raised some of the issues that have to be balanced carefully in any formula that comes forward for the allocation of the "R" component of SIFTR between your long-term curiosity-driven research, on the one hand, and health services research, on the other hand, and also recognising, I think, the variety of ways in which academic posts have been used to the benefit of the health service in the ways you yourself this morning and my colleagues have discussed. So in principle, yes, but it is all going to depend upon the detail that the formula has.

(*Professor Sir Colin Dollery*) I think there is a particular problem in that because I sit in one of those institutions. The ex-SHA hospitals, will have been taken from a situation of complete central funding into the internal market, over a very short period of time, and without the local purchasers having the funds, in many cases, to afford to buy. It is all very well being in a market and you can compete but if the purchasers do not have enough money to buy the totality of the services there will be a problem and I foresee a very difficult future for the ex-SHA hospitals unless the policy is modified to a degree.

Lord Perry of Walton

140. It is my memory when we wrote the first report of this Committee and decided to recommend health services research that we did actually suggest a separate research council altogether, and the reason for that, as far as I remember, was precisely to protect the pure research that was already covered through the MRC and otherwise. The feeling that you have is that the single stream will, in fact, divert money into health services research. Would you want to see two streams or would you just want some sort of reserve power to protect the pure research part of the single stream?

(*Professor Pattison*) My preference would be to try and make the single stream work and my concern—and I think we have expressed it in the two documents—is that whilst there is an explicit statement, quite properly, that health services research is important, there is no counterbalancing explicit statement that there is also a need in the Culyer report to maintain the long-term infrastructural core support which, after all, is going to lead into the health services research projects five, ten or fifteen years from now. So I think there is a slight worry, that whilst you explicitly state one thing, the other is not covered by a similar explicit statement. That is really our worry.

Chairman

141. Does it follow from what you said before about the universities' involvement at a regional level in the administration of the "R" component, that the universities, you feel, should be intimately involved in the appointment of R&D directors in the regions?

(*Professor Richards*) That would be our view, my Lord Chairman, yes, a rather similar situation to the appointment of the regional postgraduate deans, which are joint appointments.

142. Yes, appointed by the university but paid for from NHS funds?

(*Professor Richards*) That is correct.

143. Thank you very much. Is it the case that at the moment the universities are not involved significantly in the appointment of R&D directors?

(*Professor Sir Colin Dollery*) That is true, Lord Walton. On the other hand, if you look at the R&D directors, quite a number of them are distinguished clinical academics but they are part-time and we understand that those posts are about to be made full-time. That is likely to mean that a number of

[Chairman *contd.*]

these clinical academics will drop out because they would not wish to lose their university base.

(*Professor Edwards*) Can I make a regional point. As you know, there is no such structure in Scotland and Scotland has no regional directors of research. The Culyer report as such does not apply to Scotland. So we find ourselves in a slightly unusual situation. Obviously there is a Chief Scientist's Office and to a certain extent that has very much played this role but there is no equivalent of the structure which has been put in place in England and Wales and, therefore, at the moment we are quite unclear what the implications of the Culyer report actually might be for Scotland.

Baroness Perry of Southwark

144. I have a particular concern about the supply of people for clinical biomedical research. I was intrigued by your memorandum, where you talked about the increased demands of teaching and the impact of the Calman and Kendell reports. Would you like to dilate a little on that and what your concern is about that? Is there a shortage and is there going to be a shortage?

(*Professor Edwards*) I think the answer is there is certainly going to be a shortage. If I could make it really rather explicit. If one looks at the impact, in South-East Scotland, for example, of the Scottish Office reduction of the number of registrars from 241 in 1993 to 132 in 1996. This means that in Edinburgh, for example, we will be forced to go from 46 clinical lecturers to 16 clinical lecturers. These will be the ones in training positions and the implication of that training is likely to be that they will not be able to fulfil their academic role. So the way in which these people will function will not be equivalent to what a lecturer currently does. You ask if there is going to be a major reduction. There is going to be and we actually have the figures indicating the sort of quantum reduction, which is going to mean that obviously we cannot rely on these lecturers going on to become clinical senior lecturers, professors, etc. If the whole structure is going to be shrunk in this way then there is a real danger that the process will be damaged.

145. Do you see that problem mainly in finance or is it also that it is simply going to be very off-putting to young people who might see an academic route for their careers rather than a purely clinical route?

(*Professor Edwards*) If I can make a financial point to start off with. One of the most essential things, if you are saying what should we be doing to do to try and safeguard academic medicine, is to maintain parity of pay. Many of us are concerned that years after this problem first arose there is still no proper mechanism for maintaining parity of pay. That is a current source of irritation, not just to clinical academic staff but to all academic staff. So I think one of the most important issues is to try and make certain this mechanism is actually in place and it is an automatic one so that it is not a recurring problem. So if people can see that they are going to have parity of pay, that is an important first step but there is a whole variety of other issues. It is not just pay; there are things about conditions of service, etc. which are different, but pay is obviously an initially key issue.

146. You would not, presumably, want to tie the argument about parity of pay for clinical people to the whole university spectrum, would you?

(*Professor Edwards*) No. It is simply that I think that if there is a loss of the relationship between the NHS consultants' pay and the clinical academics' pay, then the numbers of people going into the clinical academic world would drop dramatically. There would simply be no point in their doing that.

Chairman

147. But, of course, a number of clinical lecturers do go out into full-time NHS appointments and do not all go up the academic ladder; but to what extent is this shortfall of junior clinical academic staff now being filled by appointments funded by the MRC and by the charities?

(*Professor Edwards*) I understand there is a very good set of applicants for MRC clinical training fellows and obviously what is happening is that people are going to be looking at other ways of trying to get into the academic world. But that is a very limited route if you look in terms of the numbers that are actually available, so in no way could that actually offset the prospects of reductions in applicants.

(*Professor Sir Colin Dollery*) There is also, my Lord, a differentiation I think between subjects. We are aware that it has been difficult to fill the chairs of anaesthesia, of pathology, difficult to fill senior lectureships in paediatrics, in surgery and obstetrics in a number of good universities. I spoke to Diana Garnham from the Association of Medical Research Charities last week and she said across the medical research charities they are finding that there are fewer senior registrar research fellows in disciplines like surgery now than there were seven or eight years ago. I think in internal medicine and its branches if there is a problem it is a very small one by comparison.

(*Professor Langman*) My Lord Chairman, I think we should not give the impression that quantum reductions in lecturing staffing are absolutely the same as in Scotland. There is a great unevenness from place to place about the impact and the reduction in the number of lecturers.

Baroness Perry of Southwark

148. You suggest that an enlightened Government would protect academic medicine in London through the transitional phase. Can you suggest what sort of protection you have in mind and perhaps I could take it out a bit further than the transitional phase and ask do you feel that London, as a world class centre, is going to survive given the protection?

(*Professor Sir Colin Dollery*) My Lord Chairman, I do not think London is going to expire. I am sure if we can get through this period of difficulty that we will emerge as strong as we ever were. There is going to be a period of very considerable difficulty for the next five or seven years even if the capital which is required in the NHS and university side is

[Baroness Perry of Southwark *contd.*]

forthcoming, and perhaps after the Budget statement today we shall be clearer as to whether that capital will be forthcoming. There are a number of hospitals, as you know, which are to a very substantial extent going to be closed. St Bartholomew's apparently will be completely closed, Guys Hospital will certainly be very much reduced from what it is now. There will be major changes in Bloomsbury. There was a major threat of closure to my own hospital in Hammersmith. Where there is a real threat of closure at Barts the consequence is that the good staff start to leave. That must be very threatening for the research assessment exercise which will next be done in 1996/97. In drafting that part of the paper (I was the draftsman of it but my colleagues agreed with it) what I had in mind was that for those places which had been particularly put under threat there is a need on the university side to have some mechanism for maintaining their funding until a new stability is reached and the building programmes are complete, which will, I suppose, be in five or seven years' time. I also believe that there is a need on the health service side for a recognition that the transitional funding, which is being injected into London at the present moment, will probably be needed for over that whole period. Current policy is that transitional funding is for a two or three year period and then everything will settle down. It is quite clear to me that if transitional funding is not continued until we have reached a new equilibrium then we will all be in great difficulty. That is how I would see that as being implemented.

Chairman

149. I would like to ask you about the extra administrative burden which Culyer could impose upon medical schools, particularly if investigation of the quality of research in the NHS is to be embarked upon similar to that which the Higher Education Funding Councils have undertaken, that kind of quality review. To what extent are you obtaining, or likely to obtain, support from your parent universities to assist with this additional burden?

(*Professor Langman*) Thank you, my Lord Chairman. I think having seen the amount of time and effort that has to be put into the current research assessment exercise you would not be surprised if we viewed an entirely separate exercise with separate criteria with a certain lack of enthusiasm. It would in any case suggest that the two exercises were disparate, were separate, and should not be taking account of each other and this must plainly be wrong. Our belief is that the two exercises, if there are to be exercises, should be married, should take account of the real effort required of those completing the assessments and then be done properly together.

150. Integration of these exercises would be, you think, feasible?

(*Professor Langman*) Indeed.

151. Do you think Scotland has any lessons for England in the way in which it handles the NHS and universities' interest?

(*Professor Edwards*) This is obviously a slightly dangerous question to answer. I think we have been fortunate in that we have had very close relationships between the NHS and the universities and these have been at every level. It may well be that geography is on our side but we have regular meetings between the Scottish Deans and the Chief Medical Officer and between the Scottish Principals, Scottish Deans and the Scottish Office Home and Health Department. All the medical schools have had to have liaison committees. We have had, I think, a very good process of joint planning. The Secretary of State has just announced his approval for Lothian's acute services strategy and that is with rebuilding a new Royal Infirmary and an enlarged Western General Hospital. This is a major programme costing about £200 million but it has been carried out with consultation over several years with the university. I think that the process has meant that perhaps neither side has produced an ideal but we have actually agreed on our objectives and I think the end result has been that we have avoided a lot of the problems which people have had in London where obviously there has been a process which has been much more accelerated over a short period of time. I think perhaps we have been fortunate to avoid a lot of those problems. If I can make just one final point. We have been told that it is likely that private finance would be the basis of building a new Royal Infirmary and if that was the case then we could not expect to get public money for the academic component of that new hospital and that we would also be expected to go out and raise private finance. This produces I think a whole series of new issues which none of us has previously faced. I think we need to be aware that this is very much the direction in which the Government eventually appears to wish us to go.

152. You are not proposing to take over the private hospital in Strathclyde?

(*Professor Edwards*) We are not proposing to take it over or to emulate its example.

153. Would it be possible that some of you might be willing to come back and see us at a later stage in the new year if we have further questions we would like to pose?

(*Professor Richards*) We would be delighted to.

154. Thank you very much indeed.

(*Professor Richards*) Thank you.

Memorandum from the Committee of Vice-Chancellors and Principals

INTRODUCTION

1. Information about the purpose and nature of medical schools in UK universities and their relationship to the NHS is provided in the Briefing Note attached (*not printed*). Further information about sources and volume of funding for clinical medical research is given in the attached table.

2. The Culyer Report deals with the conduct and support of Research and Development in and by the NHS. It derives much from the long established Government policies of selectivity and concentration of research funding that have been implemented by the universities and the research funding bodies that support them. We welcome that approach in general terms.

RECURRENT RESEARCH FUNDS

3. CVCP recognises that within the NHS there are at present various funding streams for R&D and that the main thrust of the Culyer Committee's recommendations is to bring them together and to make a single officer accountable for R&D expenditure and outcomes. University medical schools can only perform their task in undergraduate medical education and research in association with teaching hospitals. The extraordinary funding to provide that infrastructure is SIFTR and the Culyer proposal to separate this into teaching and a related research element prompts us to restate the purpose of these funds:

(i) They should ensure that clinical facilities are sufficient for the teaching of undergraduate medical students.

(ii) They should ensure that clinical research and biomedical science research is possible in all medical schools in order that doctors shall be educated in a proper environment.

(iii) They should ensure that the clinical infrastructure of the teaching hospitals is able to support major research activity funded by project grants.

4. Noting that SIFTR is but one of several funding streams in NHS R&D we are concerned that there could be leakage to serve purposes other than those listed above which could seriously undermine both teaching and research in universities and their associated teaching hospitals. We believe that the assessment of this research should be part of a national exercise involving both the NHS Directorate and HEFCE or its equivalent bodies in Scotland, Wales and Northern Ireland. We hope that assessment will be done through peer groups working from a common core of criteria, though the HEFCE might wish to adopt additional academic criteria and the NHS Directorate would apply user-benefit criteria. We suggest that funds for research should be directed nationally through an explicit formula that combines factors relating to quality of medical science, likely benefit to patients and appropriate volume measures.

5. We fear that difficulties are being caused by the inconsistency of planning undergraduate medical education and research nationally whilst the clinical facilities are being redistributed locally by the interaction of purchasing authorities and teaching Trust hospitals as providers. Representation of the universities on Boards at all levels of the NHS is essential to implement the Ten Key Principles (see Briefing Note) and to ensure the effective and economical use of public funds from three Government Departments (DFE, DoH, OPSS and their equivalent in Scotland, Wales and Northern Ireland).

6. Although the Culyer Report ranges over a broader spectrum of NHS research, we have concentrated above on medical research but could comment if requested on other university research of relevance to the NHS, eg in dentistry, law, social science, management science, economics.

CAPITAL FUNDING

7. A major consequence of NHS reforms for research is felt by university medical schools whose teaching hospitals are relocated and through the establishment of primary care centres. The Department for Education has made it clear that it will not fund new buildings for academic purposes to replace those lost through changes driven by the NHS. Very large sums of money are involved, typically of the order of £10 million per medical school. Local solutions have been obtained in some cases through early consultation, but several have been reported where decisions to move hospitals have been taken without respect for the Ten Key Principles of joint planning.

STAFFING

8. We have received reports from our members that recruitment and retention of suitably qualified clinical staff is growing difficult in some fields (eg surgery, anaesthetics, paediatrics, geriatrics and obstetrics). Amongst the reasons quoted are

(i) lack of confidence in the NHS as a provider of resources for teaching and research

(ii) apparent disregard in the NHS reforms of the universities' interests

(iii) a perception that career progression is more rapid and more secure in non-academic medicine.

9. On clinical academic salaries we have a long-standing problem. The salary levels of NHS consultants are adjusted annually by national negotiation in which neither the universities nor the HEFCs are represented. Our experience has been that the allowance for salary increases made by the Department for Education in university budgets has been insufficient to meet the cost of implementing the parity of pay necessary to recruit, retain and motivate clinical staff.

10. Two consequences flow from this, first a tendency for understaffing in the medical schools; second a tendency to seek greater efficiency gains from other subjects in the universities concerned. To some extent the remedy to the first effect has been for the NHS to fund directly a number of clinical posts in the medical schools. For the future we are concerned that the ability of the NHS to apply this remedy will be reduced by the disaggregation of SIFTR, the rationalisation of regional health services, and the devolution of decision making within the NHS.

25 November 1994

RESEARCH GRANTS AND CONTRACTS INCOME, 1992–93

Clinical Medicine—(Universities with Clinical Medical Departments)

Source of Income	*London*		*England*	*GB*	*UK*	
	£m	*%*	*£m*	*£m*	*£m*	*%*
1. Research Councils	22.373	14.8	37.695	45.178	45.343	15.1
2. UK Charities	66.229	43.7	113.464	129.568	130.957	43.6
3. Central Government	12.868	8.5	22.213	31.398	31.531	10.5
4. UK Industry	15.288	10.1	23.362	28.221	28.546	9.5
5. Health/Hospital Authorities	8.518	5.0	16.424	17.238	18.582	6.2
6. European Community	2.706	1.8	4.256	5.081	5.238	1.7
7. Other overseas	9.696	6.4	15.470	19.593	19.644	6.5
8. Others	13.945	9.2	16.002	19.826	20.204	6.7
9. **TOTAL**	**151.623**	**100**	**248.887**	**296.103**	**300.045**	**100**

UNIVERSITIES

England (excl London)

Birmingham
Bristol
Cambridge
Leeds
Leicester
Liverpool
Manchester
Newcastle
Nottingham
Oxford
Sheffield
Southampton

London

Imperial, St. Mary's
King's College
UCL
Charing Cross
London Hospital
Royal Free
St. Bart's
St. George's
UMDS (Guy's/St. Thomas')
BPMF
Hygiene & Tropical Med
RPMS

Wales

College of Med. Cardiff

Scotland

Aberdeen
Dundee
Edinburgh
Glasgow

Northern Ireland

Belfast

Examination of witnesses

PROFESSOR SIR MICHAEL THOMPSON, Vice-Chancellor, University of Birmingham, DR KENNETH EDWARDS, Vice-Chancellor, University of Leicester, PROFESSOR SIR DAVID WILLIAMS, Vice-Chancellor, University of Cambridge, PROFESSOR MARTIN HARRIS, Vice-Chancellor, University of Manchester, SIR WILLIAM FRASER, Principal, University of Glasgow, and PROFESSOR SIR RONALD OXBURGH, Rector, Imperial College of Science, Technology and Medicine, were called in and examined.

Chairman

155. Good morning, gentlemen, and again thank you for coming and thank you, too, for sparing the time to be with us throughout the earlier discussions that we have enjoyed with the Deans. We are grateful, of course, for your memorandum, which I accept is wholly, as you said, dealing with strategic issues. I would like to invite you, Sir Michael, to say whether you would wish to make any opening statement to us before we begin the questions?

(*Professor Sir Michael Thompson*) My Lord Chairman, if I might make a very brief opening statement, it is sometimes necessary to remind ourselves that the universities with medical schools place a great value upon them. It is, indeed, a privilege for us to be able to work with an esteemed profession in teaching those who will enter that profession and to pursue scientific research in biomedical sciences, and to do that knowing that it will have direct and obvious benefit to society through service to patients. Of course, access to patients is a fundamental requirement for any medical school and that can only be had through partnerships with the National Health Service. This is where the major challenge has always been for those who have to manage the universities and operate at that interface. The nature of the interface is in the process of changing and it is changing out of the control of the Vice-Chancellors. For that reason we welcome this opportunity to attend your Committee and to deal with our particular concern with maintaining the health and vigour of medical research in the university medical schools of this country.

156. Thank you, Sir Michael, for that very encouraging introduction. Could we then go straight into the advice that you would give to those who will be responsible for disaggregating SIFTR into the teaching and research components.

(*Professor Sir Michael Thompson*) Of course, we have studied the Culyer report with some considerable attention. We have drawn on recent experience of research assessments within the London special health authority hospitals to assist the authorities in redirecting funds in relation to the quality of the science multiplied by the benefit to the patients. We have thought considerably about this and the first point I would like to reinforce, which has already been made by the Deans, is that we do have a great deal of assessment to perform inside the universities at the moment. That is understandable and it is in response to requirements of public accountability, but not only would it be wasteful of resources, it would also, I believe, be less effective if the assessment of a teaching hospital were to be done at a different time and by an independent group of people from the assessment of the research in the associated medical school. So we would say this word "integration" is a very important one. However, thinking about the criteria that might be applied, we see that the criteria for judging the quality and the likely benefit of the research would probably contain a common core between the two sides. But I could imagine there might be additional criteria which the academic side would wish to apply, for example the value of the postgraduate research training, the PhDs. On the other hand, there might be a relationship to the users' benefit which the health service might apply. For example some indication of these things they call QALYs[1]. That said, I think our concern on reading Culyer's report is that there is a number of streams for funding research and development in the NHS, and one of those is the one talked about this morning so far; which is SIFTR and the "R" part of SIFTR. There are other kinds of research moneys, for example those which have been going to the special health authorities, those which go to the central research committee and so on. We understand that in due course all of those funding streams will come together and operate through a single channel controlled by the NHS Director of Research and Development. I think if we have a concern it is summed up in a single word, which is "leakage". We are only barely able to operate effectively with what we have coming into our medical schools and associated hospitals at present and were that money to leak away into other purposes, then I think we could not fulfil the functions expected of us and listed in our briefing memorandum. The purposes for which SIFTR was originally intended were, first, in order to ensure that clinical facilities were sufficient for the teaching of undergraduates; secondly, to ensure that teaching takes place in a research environment, and thirdly, to provide the infrastructure necessary for project grants to find well-found laboratories and well-found hospitals, in which the research can be conducted. I do fear that if joint planning according to the "ten key principles" is not followed through in future, we might find there are insufficient funds coming into our hospitals to maintain teaching and research activities, but particularly research activities.

157. Thank you. You heard what the Deans had to say about regional directors of research and development. Do you share their view that the universities should be intimately concerned with those appointments, and what would be your comments in general about the proposal that the "R" component of SIFTR and the "T" component of SIFTR should be perhaps channelled through a committee upon which the Dean of Medicine and other members of the university would sit perhaps, and certainly the regional director of R&D?

---

[1] *Note by the witness:* Quality Adjusted Life Years.

[Chairman *contd.*]

(*Professor Sir Michael Thompson*) I think that the securing of a joint planning mechanism which will work effectively at local level is absolutely crucial. It may be that a different mechanism will suit one region better than another and each of the universities with their associated hospitals will probably have to find a different way of doing it. So a committee such as has been proposed is but one way forward but I do think it would be enormously helpful if the appointment of the regional directors of research and development, who will be working as the agents of Professor Peckham's organisation, were joint appointments with the university, following the model of appointing the postgraduate deans. I would have thought then that the relationship between that individual and the dean of the medical school and the vice-chancellor was a crucial one. In fact, I see four people being very important in this: the regional chief executive officer, the regional director of R&D, the vice-chancellor and the dean of the medical school. Those four people should meet, and particularly the dean and the regional director of R&D, very regularly as part of the management team. What kind of committee forms the policy which the executive will then operate to is a matter, I think, for local decision and discussion. I do not think I would wish to comment further upon that.

158. If there is to be a similar kind of research assessment exercise integrated with that which is being sponsored or required by the higher education funding councils, is there not a danger that a single body could perhaps be thought to have a monopoly of wisdom in this area? Of course, we appreciate that some of the assessments made by the higher education funding councils have been challenged, some quite forcefully.

(*Professor Sir Michael Thompson*) If I might take that particular point of the openness to challenge, I had some personal experience of this watching the London operation performed. With hindsight I would say about that operation that it was a very expensive one and I think because it was the first time it had ever been done people did not want to be accused of having skimped in any way, so a number of committees were set up which were, I believe, very well constituted, who took advice from peer groups in the conventional manner. Unfortunately, it took place out of synchronism with the funding councils' own assessment of the associated institutions. Consequently, there was some mismatch at the interface which needed to be smoothed. I would say that some of the difficulties could be avoided in the future were it made clear that by offering to be assessed the hospital management concerned agreed to abide by the assessment. Clearly it would have an opportunity to see the recommendations in advance but it would be a condition of that hospital receiving SIFTR that the assessment would be respected.

159. If you had freedom of choice, would you prefer that the future regional directors of R&D were whole time or part-time, as indeed they are at the moment, with the opportunity of combining that responsibility with a senior academic or other appointment?

(*Professor Sir Michael Thompson*) Ideally I suppose I would like to see them being able to carry on some work in the academic field but being a practical man I do not see how that could conceivably be done. The best we could hope for is that these were people who had recent hands-on experience of running large research operations within a university medical school environment.

(*Dr Kenneth Edwards*) My Lord Chairman, can I take up a point about the mechanisms for joint planning because I think those are issues of great concern to us since existing structures are now about to be dismantled in a variety of ways. We have put, as CVCP, to the Secretary of State a list of suggestions as to how this might operate. One is that there should be a university voice, recognised as such, at the level of the NHS policy board. The second is a concern at the imminent departure of the regional health authorities in which of course we are required by statute to have a university member.

160. Yes.

(*Dr Kenneth Edwards*) We believe that getting some understanding of mechanisms that exist at regional levels is absolutely crucial to us for a variety of reasons, including a joint mechanism for jointly approving the appointment of the regional director of research and development. We are also concerned that the existing provision for university membership of the district health authorities, the purchasing authorities, should be retained when they are replaced by new authorities which presumably will be specified in the Bill when it appears. Finally, we are concerned that the universities are consulted when memberships of trust boards of teaching hospitals are made. Now I think only in the third of those categories, the district health authority, is it likely to be a matter of legislation, the rest is gaining an understanding very clearly of how mechanisms should work and how we will be consulted.

161. Thank you very much. I was going to ask you those very points because some of us fought at a very late hour for the university representation when the NHS Bill was before this House.

(*Dr Kenneth Edwards*) We are extremely grateful, my Lord, to you and your colleagues for the efforts of the House of Lords in this and other matters.

162. We will be examining this Bill when it is published.

(*Professor Sir David Williams*) My Lord Chairman, may I simply reinforce that point by urging clarity in the regulations or the legislation itself but especially in the regulations about the university involvement at these various levels because merely to leave it on the basis of one person at the university begs the question of consultation, it also begs the even more fundamental question about the flow of information back to the university from that so-called representative.

Chairman: Baroness Perry, did you wish to pursue the issue of academic careers?

Baroness Perry of Southwark

163. If the Vice Chancellors have anything to add to what the Deans said I am curious.

(*Professor Sir Michael Thompson*) My Lord Chairman, the problems that we have been facing as Vice Chancellors in filling chairs in our medical schools are becoming extreme. In certain specialities it may be due to the fact that there are not sufficient fish in the pool. In other cases it may be that because of the reorganisation of our health service locally we cannot provide an attractive base to work from at the moment so the turbulence and instability of the current situation is undoubtedly affecting things. I do fear that there are disincentives now for coming to work as a professor of medicine or professor of surgery in some fields and that a loss of confidence amongst the profession in academic careers has been engendered by the failure of the people who drafted the legislation bringing in the NHS reforms to mention the word university. It appears so infrequently it has, I think, undermined confidence in the career prospects for staff coming into work in this field.

(*Professor Martin Harris*) I wonder if I could link that point back to the previous discussion. I think one of the things the Deans said which I particularly wanted to endorse, and it links into the changed arrangements at regional level, is how important it is that there is seen to be a strategic policy involving universities' own developments but also the regional developments within the NHS. So, for example, the use of NHS funded posts alongside university funded posts can be seen as part of a strategic investment in centres of excellence, strengthening existing expertise or establishing new schools of expertise. One of the things which discourages individuals from applying for senior clinical academic posts is the feeling that in that particular area, that particular geographical or clinical area, there may not be such a strategy in place or that it may not be robust enough to be sustained during the very profound changes that are likely to go on ahead. In other words the role that the regional health authority has played has to be replicated. It is not yet clear how it is to be replicated but the universities must be crucially involved in that replication. I am sure that will not solve the problem of recruiting senior staff but it may alleviate some of the acute difficulties.

164. Do you find that since so many schools of nursing and other kinds of medical courses have been moved into higher education institutions, quite often into the new universities who are now obviously developing their own relationships with the NHS, this has confused the issue or has it made it clearer? Do you see medical schools as being able to establish a more distinctive role because nursing and other para-medical fields are being separated out?

(*Professor Sir Michael Thompson*) May I attempt an answer to that, my Lord. One of the problems I have seen developing locally in the West Midlands is that it is apparent that two universities or possibly three may be using the same hospital for the purpose of getting clinical placements.

Chairman

165. Quite.

(*Professor Sir Michael Thompson*) That may sound like a good idea but it is difficult enough to manage a hospital and its interface with one university and it would be, I believe, exceedingly difficult to operate an interface with joint planning and management with two or possibly even three. That is one problem which is facing us at the moment and I hope that it will not lead us into insoluble problems but I do think it will make the problems more difficult to solve than they need otherwise have been.

166. Students from overseas have been coming in increasing numbers to obtain clinical experience in British hospitals, not least from Germany but also from certain other countries and have been generally welcomed by the medical schools. Is there any degree of control upon that influx and is there any intention so far as you are aware that the universities, who must in a sense accept some kind of responsibility for the attachment of those overseas students to hospitals in their respective regions, should be charging fees? Do they, are they or do they intend to?

(*Dr Kenneth Edwards*) The Funding Council determines appropriate approved numbers which include a number of overseas students but of course that is a separate issue from the students coming in from the European Union.

167. Quite.

(*Dr Kenneth Edwards*) I have to say that I do not have a clear view as to how that is being tackled on a national scale.

Chairman: It will be interesting to have some information about that.

Lord Butterfield

168. When we were talking a week ago to the MRC I was concerned that the MRC would be asked to take on more and more responsibility now including health services' research without any obvious improvements in their financial position to master the increasing amount of work. It seems to me the amount of work that has been passed by the affairs of today on to your clinical or medical deans is growing and growing. They have to worry about so many things that we have talked about. In a word, do you think they are getting close to exhaustion?

(*Professor Sir David Williams*) Yes, no doubt.

169. Yes.

(*Professor Sir David Williams*) My Lord Chairman, the pressure now is huge on the medical schools enhanced by the huge uncertainty which is attached to the issues we have been discussing today.

(*Sir Williams Fraser*) I think one of the difficulties is going to be finding people to take this post on because they not only need to have administrative ability and negotiating ability but they also need the respect of their medical colleagues, and to get these combined is going to become increasingly difficult.

Baroness Perry of Southwark: Of course, one of the great sources of stress, as I think you made clear in your opening remarks, is that so much of the change is out with their control, plus feeling it is all

[Lord Butterfield *contd.*]

happening but you cannot actually get a purchase on it.

Chairman

170. And, of course, we have in the past had a considerable number of very distinguished medical vice-chancellors, of whom two are in this room today, but at the moment there are none. I think one of the problems there is the difficulty in persuading people to move out of medical science and medical practice into a purely administrative appointment; that is another difficulty. We cannot overlook the question of pay and we know that this has been a thorn in the flesh of the universities for a long time. One of the issues relating to recruitment to shortage specialties, not least in orthopaedics, has been the discrepancy between the potential rewards in the academic field, on the one hand, and the NHS practice, on the other. Can we clarify one point. I think that the battle, as it was then, over the issue of limited private practice for university academic clinical appointments was won. There is a difficulty there in that any kind of private practice may carry the risk, perhaps inevitably carries the risk, of diverting people in academic posts from teaching and research, but do all universities now accept the right to limited private practice for clinical academics? The other question to pose to you is that now we are hearing that the Government proposes to introduce local pay instead of performance-related pay in the NHS. There is a proposal under the Kendell report, that distinction awards will be paid in future directly by the NHS and not through the universities. Do you see any problems in potential disaggregation of academic pay for clinicians in the universities as between the university budgets, on the one hand, and the NHS budget, on the other? These are issues, I think, which are likely to arise.

(*Professor Sir Michael Thompson*) If I might take the private practice question and answer it as best I can and pass the performance-related pay issue to Dr Edwards—that is how we propose to divide it—the CVCP took a line on this some years ago which was more permissive than had been the case in the past. We understand that most universities now allow limited private practice on condition that the funds gained thereby by the individual are reflected back in some way into the funds of the medical school so that it does not all go into the person's private pocket.

(*Dr Kenneth Edwards*) The other issue, my Lord Chairman, is certainly a cause of major concern to us. It has been a matter of considerable importance to us to have maintained over the last few years, often with considerable difficulty and often following negotiations with the Department for Education about the supplementation, for that to maintain the parity between the salaries that we pay and the salaries that the NHS pay, and clearly if there is local settlement, local determinations of pay, which may well differ from one trust to another, both trusts operating hospitals and teaching hospitals of universities, it is clearly going to present enormous problems. We fear the danger of a free-for-all which will, in fact, cause inflation of some salaries and some considerable disparities which, apart from the disruption it would cause perhaps to harmony of people working alongside one another, would actually cause considerable problems of recruitment and exacerbate some of the problems we have already alluded to of recruiting clinical academic staff. So, yes, we do feel considerable concern on some of these issues.

(*Professor Martin Harris*) I wonder if I can add to that. A typical medical school is, of course, spread over four, five, six NHS trusts and yet we are running a unitary medical school with collegiality among that medical school. These are people employed by the university and if there come to be significant disparities between the salary structures in different trusts, each of which may have members of the university at all levels working within it, I hardly need spell out the sort of problems that could arise. I wonder if I could return to your earlier question. Clearly you cannot generalise totally about any group of individuals but it is my experience in a very large medical school that what motivates people to become clinical academics as opposed to other kinds of clinicians is not primarily pay. Pay is always an issue but it is not primarily pay, and the anxieties that one detects are not essentially about pay in general. They are about the quality of the research facilities, they are about reasonably secure funding, and above all—and this comes up over and over again—they are about the absence of uncertainty. Nothing distracts a researcher more than uncertainty about where he may be physically located in a year's time, how he may be funded in a year's time, and NHS-driven reforms, always often perfectly necessary, are unsettling academic colleagues far more than whether they earn a thousand or two less than a clinician would do.

171. There is no intention, so far as you are aware, that the universities should move away from nationally negotiated salary scales—or is there?

(*Dr Kenneth Edwards*) I think this is not a medical question, my Lord Chairman, and my colleagues are looking to me, as Chairman of CVCP, to pick this one up. I think I can honestly say at the moment there is no intention to do that. To amplify that a little bit, we would not be surprised if over the years ahead there is some breakdown in the efficacy of national negotiations.

Chairman: Of course, one problem in medicine is that if local pay or so-called performance-related pay are introduced in the NHS, we may face a situation like that in the United States where salaries are negotiated according to specialty. This could be, I think, a serious difficulty in relation to recruitment in the so-called minor specialties.

Lord Nathan

172. I wonder, Lord Chairman, whether we can have a little more discussion on the question of quality of the local directors of R&D, who seem to me from the evidence we have had today to have a crucial role in the matter. The particular points which you have raised relate to the certainty, the strategic policy within the locality, and from this the holding

[Lord Nathan *contd.*]

of senior academic professorships and so forth. All these seem to hinge to a very large degree on the quality of the people you are going to have as directors. As I understand it, they are henceforth to be full-time. They would have to be. I fully understand that. Is it your opinion that the only people who will accept such a position will be those, frankly, who are not fit for any other position or are they going to be models of saintliness?

(*Professor Sir Michael Thompson*) My Lord, that is a difficult question for a vice-chancellor to answer but it does seem to me that it is essential that the degree of autonomy of the local director of R&D is prescribed by the central NHS management system and that the key person in all this, the accounting officer, will be the NHS director of R&D. I hope very much indeed that the process of research assessment and the steering of funds for the "R" part of the SIFTR is done on the basis of nationally agreed criteria and a nationally operated assessment system, so that this will not be devolved to the local group to operate, and that the regional director of R&D will simply be the agent for the NHS director of R&D. I think if it works in that sort of way some of the fears you might have and I might have would be allayed. But I do think it would be worth repeating for the third time that I believe these should be joint appointments, not simply appointments by the Civil Service of another civil servant to sit locally alongside the regional chief executive. The model of a postgraduate dean suggests itself as one which has worked admirably well for several generations.

Chairman

173. Do you feel that the Higher Education Funding Councils and the Higher Education Funding Council for England in particular have made adequate provision for clinical and academic medicine, particularly in respect of hospital rationalisation and the associated capital costs?

(*Professor Martin Harris*) I think the answer to that is very clear. The Funding Council is in the process of making, outside London, no provision for capital costs associated with hospital rationalisation and that is not a wholly unreasonable position for them to take. The position is that when there is an NHS led hospital rationalisation it may well be that there is, in one or more hospitals to be closed or otherwise radically changed, a significant part of the local university's medical school embedded, often on a historical basis that is less than clear to contemporary financial analysis but nevertheless there it is. If there is a Department of Health led decision to relocate or to rebuild then the university has also to move its accommodation willy nilly because clearly if the patients move the associated academic activities need to be moved also. The Funding Council's view very clearly is that they have very limited capital, they have their own priorities and those priorities cannot be driven by the priorities determined by another Department of State. There is also the obvious problem that many large universities cannot even apply to the Funding Council in respect of capital bids of less than five million pounds, that is the cut off for most of the large universities, and that even above five million pounds, even if they were to be successful they would only get 25 per cent maximum of the cost. What is absolutely clear is that the capital costs of hospital rationalisation, in so far as they affect university embedded medical accommodation, do need to fall to the Department of Health. That I think is now accepted unless it can be demonstrated that there is an educational betterment—and I stress *educational* betterment—that may be being obtained and would be a priority for that university at that time in any case. Those cases are vanishingly rare.

174. Thank you very much for that helpful point. Clearly there has been a significant change. I look back to when I was a Dean in a very different era. There was, for instance, a major plan to build a new medical school and an adjacent ward block in Newcastle, for example, where there were university departments in the ward block and hospital departments in the medical school.

(*Professor Martin Harris*) Yes.

175. The arrangement ultimately reached between the then University Grants Committee and the regional health authority was that UGC would pay the entire costs of the medical school and the regional health authority would pay the entire costs of the ward block and no money would change hands in respect of that overlap. Does that kind of local arrangement no longer exist?

(*Professor Martin Harris*) I am not trying to say that the regional health authority will never contribute but certainly at central level the Funding Council made it absolutely clear that it will contribute nothing. There is a very clear example now at Oxford where there are to be major changes where the capital costs are likely to be in excess of £15 million, the academic related costs, and the Funding Council has offered and will offer nothing.

176. That is a matter of concern.

(*Professor Martin Harris*) Nothing.

177. Health science departments, by which we mean departments concerned with a very wide range of professions allied to medicine, are proliferating, particularly in the newer universities but not exclusively so; do you feel that this is having any effect on the interface between medical schools and the NHS?

(*Professor Sir Michael Thompson*) My Lord, I drew attention to one area of concern which was the management of a hospital, which contained students from several universities. There is, of course, also a local market in that many of the students who wish to study, for example, nursing, are recruited locally and will be living at home whilst they are studying so they are part-time students by definition. There is an interesting division of effort between universities with medical schools and universities without. Since the universities with medical schools are mostly of the civic variety, which did not until quite recently have large numbers of part-time students, it has been I believe the case that there has been some tendency for the new universities to pick up more of those

[Chairman *contd.*]

students than the universities who were in the medical business before. We have been somewhat bedeviled by the pension regulations and the pension arrangements for staff who were teaching in nursing colleges, physiotherapy colleges and so forth because the Secretary of State for Health has ruled that they may not carry their NHS pension with them. New arrangements have to be made and that has made the negotiations for incorporating the nursing colleges in the universities of all kinds much more difficult than it need have been. It is also reflected into the prices which have to be charged for doing the teaching. There is a problem there; it has to do with units of resource for teaching and it links back to extraneous factors such as the treatment of pensions for those who would teach in nursing and professions allied to medicine.

178. Might I just ask you then one final question and that relates to the development which appears to be escalating of schools of postgraduate medicine in universities without medical schools where, for example, the process was begun many years ago in Keele, later in Exeter and most recently in Hull. The NHS has contributed funds to create chairs in various medical specialties in these universities without medical schools with the corollary that they are likely to be engaging in research in NHS hospitals. Is this something that as a process the Vice-Chancellors Committee as a whole commend?

(*Professor Sir Michael Thompson*) If I dare speak for the Vice-Chancellors Committee, we have not considered this problem recently. We would be very willing to do so and to submit to you supplementary evidence on this very point.

179. Thank you very much. Is there anything any of your group would wish to add?

(*Dr Kenneth Edwards*) Just one final point, if I may, my Lord Chairman. Several times we have emphasised the uncertainty and I think that has been our major concern over the last few months, the uncertainty of how the changes in the NHS will impinge upon medical research and, indeed, medical education, and there is a feeling that the changes are being put into place rapidly. Perhaps they need to be put into place rapidly, but the major concern within the NHS is to ensure that a system is created which works managerially within the NHS and I think that has generated a feeling of uncertainty. We feel that we have not always had an opportunity to put our point of view about the provisions that need to be made for medical education and medical research.

180. Thank you very much. Actually there was one final question which has occurred to me, if you will forgive me. One university with which I happen to be familiar made a positive decision two or three years ago to top-slice its funding from the Higher Education Funding Council by creating a research fund for which individuals across the entire university, including medicine, could then compete. Is this a process which has been widespread throughout the universities?

(*Professor Sir Michael Thompson*) I believe not but we would have to consult our members. Many of us have followed the recommendations of the report of the committee chaired by Sir Alex Jarratt, the Jarratt report, and have tried to make individuals accountable for budget centres and to manage within those budgets a process environment, income and expenditure being contained within those budgets. Speaking for my own medical school, I would expect my dean to top-slice such funds as came into his school for that purpose within that school.

181. But not on a university-wide basis?

(*Professor Sir Michael Thompson*) Not on a university-wide basis, no.

Chairman: It would be interesting to know whether this is a policy which has been followed by any others as well. We are particularly grateful to you all for sparing the time and for bringing along such a very powerful and distinguished team. Thank you.

TUESDAY 6 DECEMBER 1994

Present:

Butterfield, L.	Perry of Walton, L.
Flowers, L.	Walton of Detchant, L. (Chairman)
Nathan, L.	

Examination of witnesses

Dr Derek Chadwick, Director, Ciba Foundation and Vice Chairman of the Association of Medical Research Charities (AMRC), Professor Dame June Lloyd, Scientific Adviser to AMRC, Dr David Gordon, Wellcome Trust, and Ms Diana Garnham, General Secretary of AMRC, were called in and examined.

Chairman

182. Dame June, and colleagues, thank you very much indeed for coming. I believe all of us involved in medical research in any way appreciate enormously the contribution which the medical charities in this country have made, and are continuing to make, to the support of medical research across a very broad field in the United Kingdom.

(*Dr Chadwick*) Thank you, my Lord Chairman. I would just like to say that we very much welcome the opportunity to be here today. We are grateful for the invitation and we look forward to further dialogue with you in the next hour and a half.

183. Could we begin by asking you what your overall response is to the Culyer report? Are there any particular recommendations which cause you concern?

(*Professor Lloyd*) Thank you, my Lord Chairman. We generally welcome the report which focused attention on the impact of introduction of the market into the research environment, and stressed the importance of providing for the needs of long-term research in the NHS; also that it emphasised that research is a national enterprise and not just to be done locally. We can support the majority of the recommendations without any difficulty at all. We are delighted with the proposal for there to be a national forum, and look forward to participating in that. We also welcome the recommendation that the central committee on research and development should be broadened, and that there is a direct recommendation that the charities should be represented there. We would certainly wish to be represented, and would be concerned if we were not, because we consider it important that the medical research charities which contribute so greatly to research should contribute to the central committee. Also, not specifically stated in the report but alluded to in the work of the regional directors, we feel there should be some representation at that level—representation so that the NHS can be aware of the way of functioning of the medical research charities (because it has become clear to us that there is sometimes not complete understanding of the way the charities can operate and do operate) both at the national level and indeed at the local level; and also that there can be good two-way communication between the desires of the NHS and what the charities' particular strategies are. I suppose we do have a concern lest the arrangements for funding research should increase the bureaucracy. I know the Culyer report emphasises that it should not, but we would be worried if that were increased. We would also be worried if only that research which was falling within the priorities of the research and development directorate and the Health of the Nation were to be considered because, as I think everybody recognises, there may indeed be other research which does not at the time fall within those priorities and which is equally worthy. We would look for a broad field there. We, of course, welcome the single funding stream. We appreciate that in the report there is mention that there would be yearly appraisal of the levy on all purchasers. We can appreciate that that might be necessary. We would be concerned, however, if that were translated into fluctuations in provision for research which needs to be on the long-term basis. Perhaps the long-term nature of the research has not been totally taken on board in the report, but in general we welcome the report and are very pleased.

184. Thank you. Others have made the very important point to us, of course, that it is crucial to see that the emphasis is not totally on so-called health service research but that biomedical research, clinical and curiosity-driven research are indeed protected in any future mechanism. Might I ask one administrative point which I think is of importance. Clearly we are beginning to receive a large number of written submissions; may we be assured that you as the AMRC can speak on behalf of all of your member charities, including I think all the major players in the field? We would find it an impossible task to try to take oral evidence from a large number of them, and we hope you can assure us that you can speak on their behalf?

(*Professor Lloyd*) Yes, indeed, my Lord Chairman. We represent 85 member charities. We have discussed this within our scientific advisory structure and within our council, and we can speak on this for all our charities.

185. Just as anyone seeking a project grant or a programme grant from the MRC or any other body must at the moment be able to say that any research involving patients has received ethical approval, the suggestion under Culyer is that such an application should in advance be considered by the local health authority if it involves clinical facilities in order to be assured that those clinical facilities are available. What is your view about this?

[Chairman *contd.*]

(*Dr Gordon*) My Lord Chairman, if I might deal with that point. This is a matter of some concern to us and we are anxious that the outcome is not a very bureaucratic process. I am sure you will appreciate that a very large number of applications come to the medical research charities, well in excess of 12,000 each year, and it would be intensely bureaucratic to require a separate signature on each one. We need a mechanism to deal with things smoothly. I am sure you and your colleagues will also appreciate that the AMRC is representing research that has been through a very fine filter before it is agreed; it has been peer reviewed and has stood up in competition. At present some of the service support which has been provided for research in the health service has been for work of less good quality, some frankly dubious. It is also important that clinical facilities are available for good quality research that, as you have alluded, is not necessarily directly, in the NHS's R&D strategy but of a more broad and long-term nature, that may be of benefit in the future. We hope that the NHS cannot act as a kind of gatekeeper just admitting research that is directly in their already delineated R&D strategy. You have already mentioned that any research involving patients would need to have consent from the relevant ethics committee, and that is given consideration before the application is made for research to be funded through the university; and we are actually asking universities to act as the conduit for the funds. 96 per cent of AMRC extramural grants go through universities. These charities require an assurance from the university authorities that all the facilities necessary for research, if it is funded, will be available. We do expect there will need to be some kind of dialogue between universities, medical schools and the related clinical facilities about the way in which they handle proposals which are coming forward to the charities. Of course, the service support we are talking about is not wantonly sought. As Culyer reminds us, it is the Secretary of State's statutory duty to provide facilities for universities' clinical research, and it refers to the relevant section of the 1977 Act. It is talking about making proper provision for serious research workers to actually carry out what all of us here desire. One other point on that is to say, of course the service costs are at the moment being spread amongst all those types of research which I have alluded to. Culyer quite clearly is putting in a quality judgment that service support should go with only the best quality research. That implies that there should be some gathering together of the funds that have hitherto been used for the weaker research; and given that funds spread widely have been gathered together there should be ample to deal with the proper service needs of projects coming through the research councils and the charities.

186. Thank you very much indeed. I had not realised it was as much as 96 per cent funded through the universities. I recall very well years ago when I had suggested that a particular research grant which I was to receive might be handled by the hospital, I learned that in order that any expenditure should be allowed out of that grant it would have to go through three hospital committees; this was one of the reasons I think many of us took all of our research to universities. You are implying that it is the university, which accepts the grant, that should accept the responsibility for negotiating with the local clinical providers that the facilities there are available?

(*Dr Gordon*) Obviously, my Lord Chairman, this has to be worked out, but it certainly has to be a dialogue, a partnership between all the relevant bodies—the research worker, the university, the clinical facility, whether it is a hospital trust or health authority, and the funding body.

187. You have seen the comments that were made by Sir Dai Rees, when he and colleagues from the MRC came before us, relating to the Concordat with the MRC—the implication being that they are in a special position because they are, in a sense, able to define priorities in the health service and that you, as charities, are not specifically concerned with that kind of identification of priorities. What is your view about that?

(*Professor Lloyd*) Clearly the charities cannot have a Concordat similar to that of the MRC, for the reasons you have just said, my Lord Chairman. The charities are independent, they are governed by their own trust deeds, they are not able to change their priorities necessarily to fit with other people's priorities, and the AMRC cannot act as a co-ordinator of their independent research. I think it is well accepted, and indeed acknowledged, that the government funding, NHS or MRC, cannot possibly support all the research that requires to be done. That is recognised by government itself. The charities can work together by sharing information to supplement the work that cannot be funded elsewhere, and also to fill certain gaps. I think, although we cannot have a Concordat in the same nature as the MRC has with the NHS, there can be, as has been put in your questions, an understanding. We would seek to develop, and are in the process of thinking this through, a series of principles on which charity supported research could appear on an equal and level playing field with the MRC, and mention has been made already of the need for peer review.

Lord Flowers

188. I should first declare an interest: I am Chairman of the Nuffield Foundation, one of your members although rather a small one from your point of view. I wanted to ask about the relationship between you and the MRC so far as your policies and practices are concerned. Given that the National Health Service has a limited amount of money to be making available for facilities for research, and given (I suppose it must be true) that the MRC and you together cause some serious strain on those resources, there has to be some sort of understanding, formal or not formal, about how you sort yourselves out. One can either say, as I think Sir Dai Rees would like to say, MRC has priority, and when its demands are met you can have the rest; he did not put it like that, but let me put it like that. Another possibility is a free-for-all; that is to say, through the universities both you and the MRC rely upon them to grab what they can; in which case you do not yourselves have a great deal of control over the situation it seems to me. Or you can have prior

[Lord Flowers *contd.*]

agreement between yourselves, the MRC and the NHS which, on the face of it I would have thought, would be the more sensible thing to do, but it is not for me to answer the questions but for you.

(*Dr Gordon*) My Lord Chairman, if I may return to a point I made earlier: service support at the moment is spread very thin over a number of activities, and if it is concentrated more on the MRC, the other research councils and the AMRC, it should not be, within the funds presently expended, a problem, we hope. A level playing field is not quite the right expression, because the MRC is an official body and the AMRC is a group of charities. It is not going to be a level playing field, it is going to be a different kind of playing field, but we hope an equally fruitful relationship with the NHS and the Department of Health. I think it is important to remember that the charities are a very large part of the whole, an important part of the whole, collectively greater than the MRC in size. My own charity, the Wellcome Trust, is itself not far short of the MRC in size. No one funding body covers the entire range. The MRC is rather weakly represented in some areas—cancer research, say; the great cancer charities are the main funders of that area of research. In cardiology the British Heart Foundation is the main funder. The charities are roughly equal with the MRC, say, in psychiatry. Therefore, if the MRC had an unreasonable advantage then those areas of research might well suffer. The mission that charities are given by their trust deeds or by the people who fund them is to do the best thing for the particular areas of research, and that research is for the public good, so there is not unreasonable claim on those public funds which provide the service support. There is also a broad range of topics we could cover if you wish on the ways in which the charities provide support for the NHS and develop things the NHS does not do itself. The training of clinicians, developing new treatments, and a lot of teaching and administration are done by charity-funded individuals. Indeed, in some subjects and some areas the charities provide much more of the research training than does the MRC.

Chairman: I was on the MRC 16 years ago and I know they gave lesser priority to some of the areas where they recognised the charities were doing a very great deal, such as cancer. I think that was quite an obvious policy decision. Having been involved personally in research, at one stage my own department received grants not only from the MRC but the Wellcome Trust and from various other charities. Like Lord Flowers, I should have declared an interest in being Chairman of one of your charities and associated with several others.

Lord Flowers: My Lord Chairman, I am not quite satisfied. Some years ago a former Secretary of the MRC, when I was talking with him about this very subject, said he did not care who paid for medical research as long as he determined the policy. That was a long time ago when the MRC was by far the dominant partner in the enterprise. The situation has changed now, and if it were to change again let us suppose you spent three or four times what the MRC spends then that point of view would be unrealistic, and you would have to make the policy for medical research in the first instance, and the MRC would have to do its best with things which, for some reason or another, you had not dealt with. I do not think we can get away with it in the slightly airy-fairy fashion you have been putting it to us at the moment.

Chairman

189. Are you aware of any situations of conflict which have arisen between the research needs and wishes of the charities on the one hand, and the MRC on the other?

(*Dr Gordon*) I am not aware of any.

(*Ms Garnham*) I think we would accept there need to be special arrangements for the very large projects where perhaps the largest charities might be working alongside the MRC, or, in some cases, in competition for funds. In the area of cancer research the UKCCR has established one way of doing this. We have to remember that very few charities are involved in research of that scale. Certainly if you take clinical trials, which has been a problem the MRC has raised, there are no charities, as far as we know, apart from those with the UKCCR involved in Phase Three trials.

190. At the moment your perception would be one of partnership?

(*Ms Garnham*) Yes.

191. And collaboration?

(*Professor Lloyd*) I think there is increasing collaboration. A certain area of research may be driven forward by a charity with a specific mission; for example the Cystic Fibrosis Research Trust which drove forward research into better care for cystic fibrosis and has been a leader in the development of gene therapy jointly with the MRC. It works pretty well, I think. I think collaboration and the sharing of information should iron out the problems.

Lord Butterfield

192. I am anxious to know whether there is developing, although you have not got a Concordat, open lines of communication. Do you have any meetings with members of the Council of the MRC to display the sort of research you are developing each year, so that they in their planning know what your minds are set on or otherwise; or is there a need for us to make a recommendation perhaps that there should be some kind of mini-forum specifically between yourselves and the MRC to ensure that there is good collaboration?

(*Professor Lloyd*) I think the Association, as I have explained, cannot really set priorities for all the charities. The Association certainly meets the MRC at various levels, with officers and with Sir Dai Rees, it invites MRC participation in our scientific advisory committee, and shares information in many areas. Our handbook indicating what charities do is widely distributed. When it comes to the individual charities, I think David Gordon is in a better position to speak.

(*Dr Gordon*) I think relations between individual charities and the MRC, when it is appropriate that there should be relations, are generally very good. The Secretary of the MRC meets frequently with the Director of the Wellcome Trust. We have many other

[Lord Butterfield *contd.*]

contacts with them, both organised and informal to appraise each other of relevant activities, so there is a very good dialogue. If I may, I will bring in Lord Flowers' point there. Yes, of course, charities must have policy for medical research; whether they are a very small charity or a very large charity, they will have a policy of the areas they wish to support. That policy of course is an independent one, because charities are independent bodies, so it is not driven by what the Department of Health or the MRC say, if they would say, a charity must do. On the other hand, it is not formulated without bearing very carefully in mind the activities of all the other funders of research. Certainly in the case of the Wellcome Trust, the Trust looks very closely at areas the MRC is active in, and aims to provide a complementary but not competitive pattern of funding. Very often we will be able to take on areas of research that are difficult for official bodies or for other charities to do. People are looking for a useful niche to fill, and they usually have a very clear-cut policy. The Trust takes a great deal of time and trouble to formulate that and to write it down.

Chairman

193. You did hint in response to an earlier question that in the past perhaps there had been some second-rate research funded by various bodies. Have you got evidence to suggest that this is something which has been fairly widespread, or is it a limited problem?

(*Dr Gordon*) My Lord Chairman, to assess the goodness and quality of research is, as you know, a very difficult question. I think if you were to try and obtain evidence by, for example, looking at the publication rate and the degree to which those publications are cited, and if you were to compare the outcome of a peer review project that had been through a member of the AMRC or the Medical Research Council, that is likely to produce high quality publications that will stand the test of time and that will be cited from the literature. The more ad hoc locally funded, less thought out non-peer review, project is much less likely to produce a peer review publication in a respectable journal, and some of the publications that appear will disappear thereafter and will not be cited. I think the evidence is in the publication record. At the Trust we are developing a system to actually look at the outcomes of research in published forms and to systematise the measurement of this outcome and to compare the outcomes of different sources of funding.

Lord Perry of Walton

194. You mentioned earlier the problem of funding curiosity-driven research, and you commented that was not in fact mentioned to any real extent in the Culyer report. How would you like to see that better covered or modified in the Culyer report; have you got any ideas?

(*Dr Gordon*) Professor Culyer, in his report, does mention in the summary at paragraph 14 that there should be funds for curiosity-driven pre-protocol research, but it is a very difficult one. There is the stage in the formulation of the research project where a protocol cannot yet be written, it cannot yet be submitted to the MRC or the research charity and does not yet need external funding to that degree, but the idea is formulating in the research worker's mind. In the case of clinical research this might mean that patients with a particular condition are brought back to the clinic more often than they might otherwise be for pure service needs while the problem becomes clear and formulated in the research worker's mind. In the report one of the ways in which research will be supported in the health service is by the provision of what the report calls "research facilities"; in other words, places which do a lot of high quality research should have funds that underpin that activity. That unpinning I think we envisage should include the possibility that a research-minded clinic should have slightly less of a service pressure on it than an ordinary clinic. I agree, it is a very difficult one to get funding for, quite right.

Lord Perry of Walton: What appeals to me about the Culyer report is that they stress all the needs that most of us see but do not give any indication of the means by which to achieve them.

Chairman

195. Is it not also the case that there is a justification for the locally operated research scheme in the NHS, for example, to allow for instance young people to take their first steps in clinical research, research which may not be of very high quality and may not lead to publications but will in fact subsequently allow some of them to develop into first-class researchers?

(*Dr Gordon*) Exactly. We find at the Wellcome that a young man or young woman who comes in for one of our highly competitive research fellowships if they had a little bit of research experience, six months or a year, funded from some local source, that usually is not the research they publish but that is the springboard which helps them.

196. Or from a charity sometimes?

(*Dr Gordon*) Or from a local charity.

Lord Butterfield

197. I am anxious that we do not get into a situation—and I believe you have already answered it—where people are only going to get grants if they are producing papers which are cited. Penicillin is an example of something which was worthwhile but not noticed by anybody. I suspect we must be very careful that fashion is not controlling the clothing the profession is wearing.

(*Professor Lloyd*) I was going to say that university clinical departments have a duty to get research done, and much of the curiosity-driven research should arise in such departments. One envisages that there will be some convergence of research facility funding and university departments. Also, the National Health Service in its training requirements for young doctors in higher training lays emphasis on some research. There is therefore in-built in the university and the NHS *a* requirement for some research facilities which are not specified for particular projects. How that is going to operate in the Culyer environment has to be worked out. I think everybody agrees that the implementation of what is an excellent report is going to be a really difficult area.

[Lord Butterfield *contd.*]

(*Ms Garnham*) I think the charities have one particular advantage, in that they are very broadly based. One of the other advantages is that, however small they are, they are not really that susceptible to fashion because they keep to their mission, the one they were set up to pursue. They focus on a particular area of concern, and they will pursue that. However unfashionable it might be, in the medical research sector there will be some people keeping that idea going. They also provide multiple sources of funding for scientists, so what might not be the priority in one place might be a priority to the charity. The Scientists report strongly to all of us that they see this as a benefit for medical scientists that other scientists in other fields do not have and are jealous. Charities have a reputation for being more responsive, and being more flexible, perhaps quicker to react to changing needs for example; more flexible about the type of funding they provide for the young clinician. When they bring together their scientific advisers, principally for peer review, they also have an ability to look at the field, to take on board what other people are doing, to identify gaps and opportunities and perhaps to target funding at those. A good example of this is the way charities run workshops in particular fields to generate research interest. They might perhaps identify the fact that there were no young researchers coming up in a particular field, that the research might be weaker than they would like to see, and they can target these areas with special funding fellowships. This is particularly important in the professions allied to medicine. Sometimes we forget charities are doing a great deal to encourage a lot of those professions to come into research, not by full year research opportunities but maybe three-month placements and shorter periods to encourage research activity.

Chairman

198. I take it you are concerned as charities that the infrastructure and the facilities available within the NHS hospitals, as in the associated university departments, would continue to be available to your members to support the research grants that they give; and that hence you are anxious no doubt about the question of overheads. What we would like to know is how you believe the new unified NHS R&D budget ought to be defined.

(*Dr Chadwick*) My Lord Chairman, could I first of all say the suggestion that perhaps it ought to be directly related to the sums spent by our members although perhaps an attractive one in some respects is not a view we have proposed, and would not expect that to be the case. We do think the size and level of activity in the overall medical research sector should be taken into account. Our key advice to you is that the sum should be fixed relative to the needs of the medical research sector.

199. Thank you. We can say exactly the same! We may be asked to put a little flesh on the bones. Have you any views about the suggestion in Culyer that there might be a 75:25 split as between teaching and research in the SIFTR formula?

(*Ms Garnham*) We live with the 25 per cent but it is, as far as I understand it, little more than a guesstimate. There is some evidence that 25 per cent may be very much an under-estimate in some Regions. I think, on the whole, we would see this as a step forward from the way in which SIFTR has been allocated in the past (based on undergraduate numbers). That mechanism has shown a real difference between the distribution of charity funding for research across regions and the way SIFTR is spread. But the 25 per cent does seem to be a bit of a guesstimate.

Lord Butterfield: It is a sleight of hand, is it not?

200. Yes, it has been plucked out of the air. If there is to be a greater emphasis on research in community care and general practice and so on, as is recommended by Culyer, this could well raise the need for additional costs. Are any of your charities effectively supporting research which you would say would be community based, or based on general practice?

(*Ms Garnham*) Yes, there are some. A particular example would be the area of stroke where there are some significant projects. Our data does not separately classified this area, but we could find out if that would be useful.

201. It would be helpful to us.

(*Dr Gordon*) At the Trust we have noticed an upsurge in the number of people coming in from primary care applying for training fellowships in areas such as epidemiology and health service research.

202. It is good to know. If you have any figures to help us in that regard it will be very useful to us. I take it you are not interested in funding research beds, are you?

(*Dr Chadwick*) No.

(*Dr Gordon*) My Lord Chairman, may I make a small point on research beds. I believe it has been said to you in evidence that this is not a system which is known elsewhere in the world. In the United States it certainly is possible to apply to NIH for a grant to set up a clinical facility which can include research beds.

Chairman: Absolutely, I am aware of that, and note that certain grants that NIH provide are grossly inflated because of the need to pay for the cost of the patients who are in those research beds.

Lord Perry of Walton

203. I would like to know how you would set about finding another Michael Peckham?

(*Professor Lloyd*) I do not think we have discussed this point.

Lord Butterfield

204. I met a noble peer walking on the carpet in this House yesterday and he spoke of the question of succeeding Peckham. I hope this will not bring the heavens down on my head forever but he said, "We must make sure he isn't a civil servant", by which I suppose he meant someone who did not wear a bow tie, paint pictures or have lateral thought!

(*Professor Lloyd*) Professor Peckham, in setting up the Research and Development Directorate, has done an enormous job in raising the whole research culture in the NHS, and for that everybody must be extremely grateful. It has been very valuable to

[Lord Butterfield *contd.*]

AMRC to have a point of contact. Clearly, the Director has not only to focus on the needs for research in the NHS, the taking forward of such research into development, but also what research is going on in the wider community. Somebody needs to know and have a knowledge of the whole research field, because integration into the NHS, both clinical research and more basic science research, is going to be important and needs to be brought on board. I think the successor to Professor Peckham has got to have a good knowledge of the working of the NHS, the needs for health services research, the workings of the wider research community, the funding mechanisms, and the way in which all those are going to be integrated. I am sure there are many such people.

Chairman

205. Yes, of course. You would be looking for someone presumably with an academic background, with research experience, and with administrative skills, among other things. Is that the sort of person?

(*Professor Lloyd*) Yes, I think so. I think a clinical research background would be enormously helpful, because you really need to have been at the sharp end.

Lord Butterfield

206. How would you react if someone came in from the pharmaceutical industry to do this job? Is it a possible route?

(*Professor Lloyd*) A personal view—I think it depends entirely on the person. I am sure there are individuals in the pharmaceutical industry who would fit the description; there are others who would not. I do not think the particular post somebody is doing at this moment should be a bar.

Lord Perry of Walton

207. Is it not a question of whether the clinical experience was there before he joined the pharmaceutical industry? Could I move on to what I really worry about more, and that is the selection of people who would be local regional directors of the research and development now that the regional authorities have been abolished?

(*Professor Lloyd*) My Lord Chairman, five of the regional directors have already been appointed. I do not know whether it is proper to say anything about how they should have been selected.

Chairman

208. Whole-time?

(*Professor Lloyd*) Yes. My understanding is we had a note of the first five appointees on a fax on Friday.

209. In that case you are ahead of us. All the existing directors of research and development, with whose names we are entirely familiar, are part-time, and practically all of them are distinguished clinicians who are doing it on a part-time basis.

(*Professor Lloyd*) If I am in error then I apologise. I looked at a fax as it came through and I was under the impression it said the first five regional directors of research and development had been appointed, and it gave a little run-down of their backgrounds. I thus do not know whether it would be appropriate for me to attempt to answer your question.

Lord Perry of Walton

210. Do you think it will be possible to find another seven or eight full-time people with the requisite background?

(*Professor Lloyd*) Now they only want another three, I think.

(*Ms Garnham*) Some of the names are familiar to us.

Chairman: It will be interesting for us to have that information. We must seek it from the Department, because we have not been made aware of those appointments having already been established.

Lord Butterfield

211. My Lord Chairman, we are in a backwater and we must recognise it!

(*Professor Lloyd*) Clearly, my Lord Chairman, it is very important that those individuals have a background in which they can really interface between the central direction, the various committees and plans for research, and what is going on locally on the ground.

Lord Perry of Walton: The point I was getting at was, it did seem to me it would be very much easier to get really high quality people to do this job if they were in fact part-time and had good administrative assistance to deal with the bureaucracy.

Chairman

212. That I think was our concern, because we were impressed by the quality of the regional directors who had already been appointed and by the range of expertise in their individual backgrounds. We were just anxious lest making the appointments whole-time would mean that individuals of that kind of status would not be so interested in taking the appointment.

(*Professor Lloyd*) When you see the names, my Lord Chairman, I think you will recognise them as having moved from part-time to full-time.

(*Ms Garnham*) One of the things we would like very much to do is develop the links between the local R&D directors and the charities, perhaps through committees or other direct formalised contact. From my point of view, I think it is quite important that those R&D directors are properly supported within the regions, and that they should have sufficient staff. I know we are always concerned about not expanding bureaucracy, but it is important that the right people are there if they are to do their job properly, and that the support is more than part-time staff.

213. We must get this clarified.

(*Professor Lloyd*) It was our information, my Lord Chairman.

214. What about recruitment and retention of high quality clinical researchers at career grades? One matter which was of great importance to the health service at one stage was that there were certain charities that were willing to endow full-time

[Chairman *contd.*]

research posts; that, of course, with the increase in costs of endowment, has largely gone by the board. We know, of course, the Wellcome Trust do provide a cadre of senior posts on a rolling basis at senior lecturer level almost like clinical research professorships of the MRC. What is your view as a group of charities upon this principle?

(*Dr Gordon*) Yes, you are quite correct, of course, the Wellcome Trust does fund people at a senior level and is fortunate in having the resources to do so. I think in the question as you posed it to us earlier, "recruitment" was the word which was there and recruitment is important. You have to get people into the system at an appropriate stage and give them adequate funding in an appropriately flexible way at a high standard which lets them get to the stage where they are appointable to that career position. Then when they get to the stage when they are fully trained and they have their ideas, and they really need protected research time, you must not let them fall when they leap at that moment. It is a difficult issue because to support a group of senior fellows at senior lecturer level or above, is really very expensive, and even for a giant foundation like the Wellcome Trust "the total commitment" is one at which we look very carefully and make sure nothing is entered into it which cannot be really seen through. It is also possible for some of the very large charities, the major cancer charities and the Heart Foundation and so on, to support people at this level, but for the smaller charities it is not possible. As ever, it relies very much on the partnership between the charities, the universities and the related clinical base, and the research councils, as many of the people who have been funded at a senior level by the Trust or by another charity move into a university appointment and are able to continue their research. I think we should hope to develop a flexibility in careers which we see in some other countries where, as people's interests evolve, they should be able to take bigger or smaller roles in research or in teaching or in administration.

215. I think it is important to examine your experience, because for many years you have been offering senior research fellowships in clinical science and also Wellcome senior lectureships on a five to eight year rolling basis, or something along those lines. That, of course, has been very helpful, not least in the case of people who may have run out of research steam during the tenure of those appointments and who then may need to move back into either clinical medicine or into an administrative appointment of some kind. Have you ever encountered any serious difficulty in relation to these appointments, finding that people were not able easily to move out of such posts into a tenured appointment of some other type?

(*Dr Gordon*) With senior clinical fellows, to which you allude, we have analysed the outcome of every one of those appointments since the scheme started in 1962 and everyone has moved from the scheme and found an appointment appropriate to his or her interests at the end of the Trust's funding. Some people move more readily than others, of course, and some people move into a higher level appointment than others, but the general outcome of that kind of funding is very happy and I think it is a measure in part of the vision of those who thought of the scheme, which was conceived by Sir John McMichael, and in part it is a tribute to the care with which fellows of this type have been selected.

Lord Perry of Walton

216. You quote in your evidence to Culyer that the charities are currently supporting 127 consultants, 116 senior registrars and 246 registrars. Are these appointments supernumerary to the appointments made by the NHS? They are all supernumerary, are they?

(*Professor Lloyd*) Yes, they are; they are an addition to the workforce. The consultant staff are a real addition, the training staff come within what is currently a quota of trainees in order that there may be room for them to move out at the other end. But they are supernumerary in the term you were asking about.

Lord Flowers

217. If you do not provide them, how many of them would the NHS have to provide anyway?

(*Professor Lloyd*) In order to do the clinical service? The actual addition to the clinical service which the training fellows give, which is not very great because they are supposed to be being trained in research methods and indeed they are, but nevertheless they do contribute to clinical care. So there might be a small need for clinical care, if there were no training fellows, but of course there would be a need for more people in order to carry on the senior tasks to which many of these training fellows go. There are thus two arms to the question. The provision of training for research is something which the Health Service would have to provide if there was no research training provided by MRC or charities.

Chairman

218. It has been suggested to us that there is an absolute requirement they should undertake to spend 60 per cent of their time on research, and when there is a training requirement 40 per cent can be involved in clinical service and training or teaching. Is that fair comment?

(*Professor Lloyd*) Our recommendations are that not more than two sessions a week should be spent in clinical service which is not related to the actual research. More may in fact be spent in clinical service but it relates to the research.

219. Indeed.

(*Ms Garnham*) There are in addition, posts which are not classified as research. There are Charity funded posts which are 80 per cent service. For example, the Leukaemia Research Fund supports posts in its research department, and its units, where 80 per cent of the time is taken up with service commitments.

220. What would be your objective in doing that?

(*Ms Garnham*) These people spend 20 per cent of the time undertaking research training, so principally it is to encourage more people to do the research, but in so doing to also the quality of service.

[Chairman *contd.*]

221. But they would be the exception rather than the rule?

(*Ms Garnham*) They are the exception. For these types of post the commitment from the charity tends to be longer-term and it is therefore an option which is really only open to perhaps half a dozen of the larger charities.

222. Do you see any prospect whatever that in relation to the clinical services given by these research fellows you may wish ultimately to invoice the NHS for those services?

(*Professor Lloyd*) There certainly is a knock-for-knock on the side of donation of service support from the charity-supported staff to the NHS. I do not think any of the charities would wish to be involved in directly costing or charging for that. It would be expensive and time-wasting.

223. Would that become any more likely if the NHS were to start charging charities overheads on research grants?

(*Professor Lloyd*) Yes, inevitably it would. We have tried to collect evidence of where this has been happening to date, and we have a little evidence of charities being charged, for example, for the use of an outpatient room to conduct a clinic, and various aspects of that sort and some of the additional diagnostic tests. We have advised our member charities to resist this and say it is in the current SIFTR arrangement. My own view is that it would be a great pity to get into a situation of itemising all this and cross-charging it; it would be an enormous waste of money.

224. This is one of the reasons why this Sub-Committee has been established, to examine this very point. If you have any evidence of your charities being charged in that way, we would very much welcome actual, concrete information. Meeting today for the first time in the adjacent room is Lord Dainton's Sub-Committee which is examining the whole issue of careers for graduate scientists in research. We are fully aware of the problems which have been encountered, not just by charities but by others, in funding posts for scientists without medical qualifications to work in clinical departments on a series of short-term appointments. Do you have any easy solution to this problem to offer us which we could pass on to Lord Dainton?

(*Dr Gordon*) No, my Lord Chairman, we do not have an easy solution, but if Lord Dainton finds one I hope he will tell us! My primary responsibility at the Wellcome Trust is to deal with people's careers and we have a clear picture of the way in which the clinical researcher's career develops and moves to and fro between the Health Service, the universities and external support. The basic scientists are more of a problem because they have less flexibility, and also in the university system as a whole there are many more of them, and all charities are looking to provide a portfolio of support which does not create a bulge of research workers at any particular stage in their career, who then cannot be either recruited or coped with in the long-term. It is certainly a very live issue with all our charities and with the universities, and it requires eventually thought and contribution and partnership with all those involved. I do think there is a slight easing of the problem in the way in which all departmental boundaries are to some extent falling. People do not work as much as they used to in a rigidly defined department of neurology or medicine or surgery, they work in a much more multi-disciplinary way and it is therefore much easier to have people carry on their careers through that structure.

225. We have dealt with the threat to curiosity-driven clinical research, and the main question relates to the availability of patients to participate not just in clinical trials but also in other aspects of research. The point has been made to us from several sources that with the internal market in the NHS it is becoming increasingly difficult for patients to be referred from, say, district hospitals to centres of excellence, either as extra-contractual referrals or as tertiary referrals, because of the differential costing between the main research centres on the one hand and what they must charge for clinical care and the charges levied by other hospitals on the other. Do you believe that the Culyer mechanisms proposed will protect that particular process?

(*Dr Gordon*) I think, my Lord Chairman, that if the Culyer proposals are implemented in the spirit in which they are intended then they should to some extent protect that kind of work. But we all acknowledge that it is extremely important, and it is one of the most difficult points and was mentioned earlier, that you may have a requirement for more patients in a particular clinic or an expert in a particular field to gather patients from a long way away, and we know this is becoming very difficult. We have less evidence of it impinging on research at the later stage, at the external funding stage, but plenty of evidence and examples, which we can discuss if you would like, of ways in which it is causing problems at an earlier stage. Indeed research results are now appearing which would not have appeared if the patients had not flowed in.

Lord Butterfield

226. I would very much like to hear about that because there was a question about rare diseases in the House the other day, and you asked a very pointed question, my Lord Chairman. I was on the point of trying to develop a theme which arose through the neurologist's eyes of Professor Hughes who works on the Guillain-Barré syndrome, which is a rare but nasty disease and you may end up on a respirator and a few may die. In the old days 10 per cent died but experts can now keep 98 per cent alive and get them out of their wheelchairs much more quickly than before, mostly by plasmapheresis. He used to get 20 patients referred to him a year and now he is down to four. One of the reasons it is down to four is that the purchasers say that Guy's is too expensive and they will not send their patients to him.

(*Dr Gordon*) This is a subject on which we all feel strongly. In the case Lord Butterfield is alluding to, the way in which patients may not be getting the optimum care because they are not going to a man like Professor Hughes, that is very clear-cut; one can say patients are not doing well because they are not seeing the best person. But I think the case is also there on research grounds. The example I have

[Lord Butterfield *contd.*]

immediately in my mind concerns, Sir David Weatherall, Professor of Medicine at Oxford, who has an interest in thalassaemia, a pretty rare condition. Alpha thalassaemia is not a serious problem and yet Sir David has gathered patients from a very wide geographic spread to follow them through to see how they respond. One group which eventually emerged from that pool of patients were those thalassaemia patients with sex-linked mental retardation. Once you have a group of patients re-defined, you can then look at what the basis for that particular problem might be, and that has led not only to the discovery that this is a sex-linked problem and localised to a particular chromosome, but also there are very exciting advances going on to delineate the precise defect. If those patients had not been gathered together over the years from a very wide range, that particular outcome might not have occurred. We would all welcome a really positive result given that this could define the pathogeneses of one cause of mental subnormality; a really vitally important area.

Lord Flowers

227. Wherever I go in the educational or research world these days, in whatever agency, I hear about the rising tide of bureaucracy and bureaucratic conditions imposed upon them by Government or by its agencies or charities or by themselves. Is it your impression that this is a real phenomenon, that bureaucratic interference, however well-intended, has increased rather sharply and is continuing to do so?

(*Ms Garnham*) This is not something which the charities have created. However I would say that I think there has been a move from the public funding bodies to greater accountability, which may have meant more form-filling. But we would consider greater accountability to be desirable. It has been much better for the Association to have more information about what happens to Government funding, and certainly that could not have been achieved without an increase in the amount of administration. However, a lot of the people who are funded by charities, particularly clinicians, report they are spending an awful lot of time on the bureaucratic side of their work rather than academic research. I would imagine that is a greater concern for the universities than charities.

(*Dr Gordon*) If I might add to that, my Lord Chairman, the charities themselves regard it as an obligation to keep their bureaucracy as parsimonious as possible; our job is to get money to research and not use it to just run the charity. The research workers funded by a number of charities comment on the outcome of this, that they find it easier to deal with us than some of the more official bodies.

Lord Perry of Walton: I think we would all agree with you that the "R" element of SIFTR ought to be directed to those clinical departments which have a record or potential for research. That would mean, would it not, a well-found clinical department? Would you be equally in favour of going back to the dual support system where well-found basic departments were continued?

Chairman

228. We were assured by the Chancellor of the Duchy of Lancaster that the transfer of the infrastructure funds from the higher education funding councils to the research councils related only to research supported by research councils and not to research supported by charities. I do not know whether that is your experience, because I think it follows from what Lord Perry says. What is your feeling about that? I know many of those in the MRC-supported departments are uncomfortable with the present situation.

(*Ms Garnham*) The Association has a position statement that charities do not support the infrastructure cost of universities on responsive project grants, programme grants and fellowships. This recognised that there is a growing area of second level funding, the sort of inter-disciplinary, longer-term, more strategic funding which some charities have become involved in. Both these are different from the provision of the infrastructure in universities or hospitals, and charities do not support that. We made that original statement in 1988. Since then there have been lengthy discussions with the funding councils. We welcome the fact that all but one of the councils have made a statement in policy documents this year saying funding of universities is to support the infrastructure costs so the direct costs can come from research councils and charities. I think we have gradually changed the climate on this issue. There is a slight difficulty in the way the formulae work out, and we are looking into that in greater detail, because it may be that research council grants actually do better even with the formulae adjusted as they are. For example, in England there is a charity volume measure in the formula and that may well balance departments against the money that was transferred to the Medical Research Council. In Scotland the situation is slightly different as all external funding is taken into account. But they include charity funded people in the staff volume measure and we need to look at how this works out for the charities. It is a much more complicated system for us as instead of dealing with one formula and one funding council, we are dealing with four formulae and four different funding councils. Trying to establish a position now for all charities and all universities is obviously much more complex.

229. So that implies in this regard Scotland is the odd man out?

(*Ms Garnham*) As far as we are aware that is true. But I should say that the Scottish Funding Council believe their formula works more in our favour, and until we look at the data we cannot be sure.

230. The relative performance of England, Scotland, Wales and Northern Ireland in handling the interface between medical research and the NHS. Have you any other views on this?

(*Dr Gordon*) We obviously do not all have experience of all the different countries of the United Kingdom. Generally things work much the same in each place. We do, I think all of us, look with some concern at the situation which developed in Wales where Professor Russell took an appointment to be the NHS lead in R&D and felt only able to remain for

[Chairman *contd.*]

a year or so before moving to another post. I think it is a pity that the mechanisms were not in place to keep someone like that in such an important area as the Principality, where there are great opportunities for research in the Health Service.

231. What about the uncertainties in London? We are aware, of course, of the great deal of turmoil in hospital reorganisation in other major cities. Do you feel these changes in the NHS are having an effect upon your decisions in relation to research funding?

(*Ms Garnham*) Most charity funding is of course in project grants and fellowships and other forms of short-term funding. There is no evidence that that has actually been affected and it is about 70 per cent of the charity money. The rest is in a mixture of slightly longer-term or unit type funding, and there is evidence that charities are falling back from those sorts of decisions for London. Undoubtedly this will affect other city centres as well. The Association deplores this period of indecision, and the blight has certainly seen a number of individual scientists, who have been charity-funded, move away from London. There is a sense also, that over the last three to five years, some of the London centres may have missed out on some of the capital-type donations which charities might otherwise have made. Hopefully we are seeing an end to this period for London, and the Association believes it is very important that the same situation is not allowed to develop elsewhere.

232. The MRC have had a mechanism, I believe, for some years whereby any royalties derived from inventions which were supported by themselves are divided according to a formula between the supporting organisation, the university and the department in which the research is being undertaken. Have you any similar mechanism across the board of your charities?

(*Ms Garnham*) We have been exercised by this for some time. We need to wait for the Charity Commission to publish guidance on the responsibilities of trustees with regard to the intellectual property of research funded by charities. It is complex because charities very rarely fund the full cost of the project, so there is always a partner and very often a series of partners over the period of the research. I am not sure it will be possible to come up with a set percentage formula which charities would be able to put into a contract or an agreement. We have worked on a form of words which gives the university a duty to share benefits but we are awaiting the advice of the Charity Commission as to whether that goes far enough.

(*Dr Gordon*) Some of the larger charities of course are more affected by this than the smaller ones. Certainly the cancer research charities have very often supported work which has led to new therapeutic entities and they have developed a mechanism for taking forward those new potential drugs into the pharmaceutical industry and make sure they are developed. Some of those developments have been quite successful. It is a complex issue because not only is one wanting to protect the flow of benefit from any development and protect the intellectual property which has been generated, one also has to make sure the charities are not inadvertently funding research in a way which is not charitable. So we are taking particular care over advice on this subject. The Wellcome Trust is actually involved in a joint venture with the Cancer Research Campaign to set up a new company which will help both those charities with this problem, and it is based on the Cancer Research Campaign's experience with CRCT, Cancer Research Campaign Technology, a separate company, so we are using their expertise and building on it and we hope that will be useful.

233. Another point was about the anxiety that you had about the initial approach of the Charity Commission suggesting that charities should be responsible for the research which was conducted on their grants. That anxiety has now been fully resolved, has it?

(*Ms Garnham*) It is difficult to know until we see the final published version of the advice, but as far as we are aware they will be holding to the second set of principles published in June.

234. As far as you know, that seems to be satisfactory?

(*Ms Garnham*) Notwithstanding the issue of intellectual property, and advice on the duties of trustees. Some charities do not have the expertise to exploit research in any way and in many instances do not have the expertise to know whether the universities are doing all they could be doing. It is the question of how far the Charity Commission wishes charities to go down that road.

Lord Butterfield

235. If one walks around the beds in a hospital, one is conscious that an enormous proportion is filled by people who have inflicted illness on themselves. I do not just mean AIDS but over-eating and all the other things. It is quite clear to me that we are desperately ignorant of the ways that we can reach the non-co-operative part of the public. For example, when I went to Bedford in 1962 32 per cent of the people did not want to know that we were looking for diabetics. It appears that all the time we are missing a large proportion, it may be a third, perhaps less, of people who just are not interested in what the establishment view of health and disease may be all about. We have been trying, and there is something called the Health Promotion Research Trust, to probe this but we have now exhausted our funds and I would be obliged if you could give me an *ad hoc* answer to this question. If people whom we know of, who have got good ideas for research in the process of health promotion, come to charities, are they likely to be rebuffed or are they likely to be listened to?

(*Ms Garnham*) Obviously most charities within the AMRC are disease-specific. Although they do a lot of work in terms of public education about those diseases they are reaching, often, a public which already suffers from the disease rather than those who do not, yet. Having said that, I think a lot do educational work on the causes of disease. If somebody was to come to the AMRC with ideas for research, we could certainly identify a number of charities which have a broader remit and would be prepared to fund social science research. Some of the larger charities, for example the Cancer Research

[Lord Butterfield *contd.*]

Campaign, have a whole department devoted to education and schools. There is a good deal of experience in this area with the charities.

Lord Butterfield: Thank you, that is very helpful. I have to tell you that it is my personal experience, talking to young people standing on the steps of their schools in Cambridge smoking cigarettes, that we are not actually converting the messages that we are all putting out into thought-processes in their heads. This is, to my mind, a tantalising problem. One of the difficulties about it is that you are getting rather close to trying to control people's behaviour, and you go down that line at your peril, particularly if you get involved with the political side. There is a lot to be found out about the non-co-operative patients. Thank you, my Lord Chairman.

Chairman: Thank you very much indeed. We are very grateful to you for coming along and giving us your time.

WRITTEN EVIDENCE

Letter to the Chairman from Professor RAC Hughes, Department of Neurology, Guy's and St. Thomas' United Medical and Dental School

I would be grateful for your help in bringing to the attention of the government the adverse effect which the new purchaser-provider arrangements have had on research. My department has had a longstanding interest, almost unique in the UK, in inflammatory neuropathy. I have noticed that the number of referrals of patients with Guillain-Barré syndrome and chronic inflammatory demyelinating polyradiculoneuropathy has fallen during the past two years. Several consultants, for instance Dr F Schon in Croydon and Dr J Rees in Brighton, have advised me that they have been inhibited from making referrals by the reluctance of their local health authorities to bear the costs.

The figures for referrals of Guillain-Barré syndrome for recent years have been:

1989	20	
1990	26	
1991	26	
1992	19	
1993	16	
1994	4	(first ten months)

The mortality from this disease in SE England was 13 per cent in 1983–84 before we encouraged a policy of transferring these patients to Guy's[1]. From 1985–1990 the mortality for GBS in Guy's was 2.8 per cent[2]. While part of the reduction in mortality may have been due to the introduction of plasma exchange, the major factor is likely to have been the concentration of patients in one unit with a special interest and experience of the condition.

I am concerned that the trend to keep these patients in smaller peripheral units will adversely affect their outcome. This trend has also seriously affected our ability to recruit patients to an international randomised controlled trial of plasma exchange versus immunoglobulin versus combined treatment which I am coordinating.

One method of mitigating these effects would be for investigators with grants to investigate or treat patients with certain conditions to be granted a licence to accept referrals from any UK health authority for that condition without attracting a charge. I fear however this would introduce another layer of bureaucracy.

19 October 1994

---

[1] Winer JB, Hughes RAC, Osmond C (1988) A prospective study of acute idiopathic neuropathy. I. Clinical features and their prognostic value. J Neurol Neurosurg Psychiat 51:605–612.

[2] Palace JA and Hughes RAC (1994) Guillain-Barré syndrome with severe persistent disability: relationship to hyperacute Guillain-Barré syndrome. Eur J Neurology 1:21–27.

ISBN 0-10-478495-4

9 780104 784952

Printed in the United Kingdom by HMSO
Dd 19585 C6 1/95 179137 PP

HMSO publications are available from:

HMSO Publications Centre
(Mail, fax and telephone orders only)
PO Box 276, London SW8 5DT
Telephone orders 0171 873 9090
General enquiries 0171 873 0011
(queuing system in operation for both numbers)
Fax orders 0171 873 8200

HMSO Bookshops
49 High Holborn, London WC1V 6HB
(counter service only)
0171 873 0011 Fax 0171 831 1326
68-69 Bull Street, Birmingham B4 6AD
0121 236 9696 Fax 0121 236 9699
33 Wine Street, Bristol BS1 2BQ
0117 9264306 Fax 0117 9294515
9-21 Princess Street, Manchester M60 8AS
0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
01232 238451 Fax 01232 235401
71 Lothian Road, Edinburgh EH3 9AZ
0131 228 4181 Fax 0131 229 2734

The Parliamentary Bookshop
12 Bridge Street, Parliament Square,
London SW1A 2JX
Telephone orders 0171 219 3890
General enquiries 0171 219 3890
Fax orders 0171 219 3866

HMSO's Accredited Agents
(see Yellow Pages)

and through good booksellers

©Parliamentary copyright House of Lords 1995
Applications for reproduction should be made to HMSO

ISBN 0 10 478495 4